

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

16432

16423

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FORT HOWARD</b>		c. LENGTH OF STAY IN lb <b>2 DAYS</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>VETERANS ADMINISTRATION HOSPITAL</b>		e. STREET ADDRESS <b>2318 BRYANT STREET</b>	
3. NAME OF DECEASED (Type or print) First <b>ALBERT</b> Middle <b>-</b> Last <b>AARON</b>		4. DATE OF DEATH Month <b>DECEMBER</b> Day <b>20</b> Year <b>19 67</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>NEGRO</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>4/2/1905</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>LABORER</b>		11. BIRTHPLACE (County & State, or foreign country) <b>GREENWOOD, SOUTH CAROLINA</b>	
13. FATHER'S NAME <b>ARTHUR AARON</b>		14. MOTHER'S MAIDEN NAME <b>NANCY MINION</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>YES WW II</b>		16. SOCIAL SECURITY NO. <b>213 07 20 63</b>	
17. INFORMANT <b>CLIN.RECORDS, VA HOSPITAL, FT HOWARD, MD.</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CONGESTIVE HEART FAILURE</b> 4200 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>ARTERIOSCLEROTIC HEART DISEASE</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>RECENT</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>BENIGN PROSTATIC HYPERTROPHY</b>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (1) (this hospital) attended the deceased from <b>12/18/67</b> , 19 <b>67</b> , to <b>12/20/67</b> , 19 <b>67</b> , that (we) (we) last saw the deceased alive on <b>12/20/67</b> , 19 <b>67</b> , and that death occurred <b>6:15A</b> M, from causes and on the date stated above.			
22a. SIGNATURE <b>John D. Talbert</b>		22b. DATE SIGNED <b>12/20/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>JOHN D. TALBERT, M. D.</b>		22d. ADDRESS <b>VAH FORT HOWARD, MARYLAND</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE THEREOF <b>12-26-67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>BALTIMORE NATIONAL</b>	23d. LOCATION (City or Town) (County) (State) <b>BALTIMORE, MARYLAND</b>
24. FUNERAL DIRECTOR <b>MORTEN &amp; DYETT FUNERAL HOME</b>		25a. REC'D BY REGISTRAR <b>DEC 21 1967</b>	
25b. REGISTRAR'S SIGNATURE <b>Laurens St. Baltimore, MD.</b>		25c. REGISTRAR'S SIGNATURE <b>Laurens St. Baltimore, MD.</b>	



CHARTER

CHARTER

CHARTER

CHARTER

CHARTER

CHARTER

CHARTER

CHARTER

CHARTER

CHARTER

CHARTER

CHARTER

CHARTER

CHARTER

CHARTER

CHARTER

CHARTER

CHARTER

CHARTER

CHARTER

CHARTER

CHARTER

CHARTER

CHARTER

CHARTER

CHARTER

CHARTER

CHARTER

CERTIFICATE OF DEATH

16433

16424

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>—</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>PERRY HALL</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BALTIMORE</b>	
c. LENGTH OF STAY IN lb. <b>1 YR.</b>		d. STREET ADDRESS <b>3227 KENYON AVE</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>4134 BROOKFIELD RD</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>JEPHTHA</b> First Middle Last		4. DATE OF DEATH <b>DEC. 28</b> 19 <b>67</b> Month Day Year	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>JAN 4 1895</b> 72 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>ESTIMATOR</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>BALTO GAST-ELEC</b>	9. AGE (In years last birthday) <b>72</b> yrs.
11. BIRTHPLACE (County & State, or foreign country) <b>PASSAIC N. J.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>JOHN ABBOTT</b>		14. MOTHER'S MAIDEN NAME <b>ROSE McMANUS</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>YES</b> <b>WW I</b> (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <b>212-05-4000</b>	
17. INFORMANT <b>WILLIAM CARTER</b> Address <b>4134 BROOKFIELD</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <b>4201</b> IMMEDIATE CAUSE (a) <b>Acute myocardial degeneration.</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Coronary Arteriosclerosis.</b> (c) <b>Generalized Arteriosclerosis.</b>			INTERVAL BETWEEN ONSET AND DEATH <b>10 yrs.</b> <b>10 yrs.</b> <b>6 mos.</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (the physician) attended the deceased from <b>July</b> , 19 <b>57</b> , to <b>12/28</b> , 19 <b>67</b> that (I) (we) last saw the deceased alive on <b>Dec. 21</b> , 19 <b>67</b> , and that death occurred at <b>9:30 A.M.</b> , from causes and on the date stated above.			
22a. SIGNATURE <b>Theodore E Evans</b> M.D.		22b. DATE SIGNED <b>12/28/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>THEO DORE E EVANS</b> M.D.		22d. ADDRESS <b>9660 BELAIR RD.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE THEREOF <b>12/30/67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>BALTIMORE CFM.</b>	23d. LOCATION (City or Town) (County) (State) <b>BALTO. MD.</b>
24. FUNERAL DIRECTOR <b>THE DIPPEL BROS INC</b> ADDRESS <b>7110 BELAIR RD</b>		25a. REC'D BY REGISTRAR <b>JAN 2 1968</b> 25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filed with the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

16434

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MD  
CERTIFICATE OF DEATH

16425

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Holbrook</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>CHARLIE HILL Nursing Home</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before a. STATE <u>Maryland</u> b. COUNTY <u>Howard</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Elliott City</u> d. STREET ADDRESS <u>CLARKSVILLE PIKE</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Charles W. Anderson</u> First Middle Last 4. DATE OF DEATH <u>DEC 21 1967</u> Month Day Year		5. SEX <u>MALE</u> 6. COLOR OR RACE <u>WHITE</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>3-27-1890</u> 9. AGE (in years last birthday) <u>77</u> yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>FARMER</u> 11. BIRTHPLACE (County & State, or foreign country) <u>TENN.</u> 12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME <u>MELVIN J. Anderson</u> 14. MOTHER'S MAIDEN NAME <u>MARY ?</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service) 16. SOCIAL SECURITY NO. <u>?</u> 17. INFORMANT <u>M. J. Anderson</u> Address <u>HANOVER, Pa.</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Detachment of Heart</u> 4214 DUE TO (b) <u>Cor. Valv. Heart Dis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that death occurred at _____, M. from the causes and on the date stated above.			
22a. SIGNATURE <u>Wm E. Martin</u> 22c. PHYSICIAN'S NAME (Type) <u>Wm E. MARTIN</u>		22b. DATE SIGNED _____ 22d. ADDRESS <u>Randalltown Md</u> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> 23b. DATE THEREOF <u>12-24-67</u> 23c. NAME OF CEMETERY OR CREMATORY <u>CRESTHAWN</u> 23d. LOCATION (City, town or county) (State) <u>W. FRIENDSHIP Md.</u>		24. FUNERAL DIRECTOR <u>Higginbotham Black</u> ADDRESS <u>Elliott City, Md</u> 25a. REC'D BY REGISTRAR <u>Charles Judge</u> 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u> DATE <u>DEC 27 1967</u>	

1942

1942

1942

1942

1942

1942

1942

1942

1942

1942

1942

1942

1942

1942

1942

1942

1942

1942

1942

1942

1942

1942

1942

1942

1942

1942

1942

1942

1942

1942

1942

1942

1942

1942

1942

1942

1942

1942

1942

1942

1942

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If only delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE  
HEALTH DEPT.

Items 18&21 Film 397  
12-7-68 ams

16435

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

16426

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>BALTIMORE</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>St. Joseph Hospital</b>		d. STREET ADDRESS <b>1655 E. Northern Parkway</b>	
3. NAME OF DECEASED (Type or print) <b>CATHERINE (RENA) M. ARMSTRONG</b>		4. DATE OF DEATH Month <b>December</b> Day <b>27</b> Year <b>1967</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3/1/05</b>
9. AGE (In years last birthday) yrs. <b>62</b>		10. IF UNDER 1 YEAR Months <b>27</b> Days <b>19</b> Hours <b>67</b> Min.	
11. BIRTHPLACE (State or foreign country) <b>Baltimore, Md.</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>John A. Forster</b>		14. MOTHER'S MAIDEN NAME <b>Barbara Fichtner</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Edwin M. Armstrong, husband, above</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <b>3220</b> IMMEDIATE CAUSE (a) <b>Cerebral hypoxia</b> DUE TO (b) <b>Shock probably secondary to acute ethylism</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
21. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.		22. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
23. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		24. (City or town) (County) (State)	
25. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		26. DATE SIGNED <b>December 28, 1967</b>	
ACTUAL SIGNATURE <b>Charles S. Springate</b> EXAMINER'S NAME (Type) <b>Charles S. Springate, M.D.</b>		27. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> Address (Street, city, town, or county)	
28a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		28b. DATE THEREOF <b>12/30/67</b>	
28c. NAME OF CEMETERY OR CREMATORY <b>Holy Redeemer Cem.</b>		28d. LOCATION (City or Town) (County) (State) <b>Baltimore, Md.</b>	
29. FUNERAL DIRECTOR <b>Schimunek Funeral Home, Inc.</b> <b>3331 Brehms Lane</b>		30. REC'D BY REGISTRAR <b>DEC 29 1967</b>	
31. REGISTRAR'S SIGNATURE <b>Judge</b>		32. REGISTRAR'S SIGNATURE	

02201

70007

200-1000

200-1000

200-1000

200-1000

200-1000

7

200-1000

200-1000

200-1000

200-1000

200-1000

200-1000

200-1000

200-1000

200-1000

200-1000

200-1000

200-1000

200-1000

200-1000

200-1000

200-1000

200-1000

200-1000

200-1000

200-1000

200-1000

200-1000

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

16436

16427

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Mount Wilson</b> c. LENGTH OF STAY IN 1b <b>39 DAYS</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Mount Wilson State Hospital</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>FREDERICK</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>WOODSBORO</b> d. STREET ADDRESS <b>10-2</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>ELIZABETH M. ARNOLD</b>		4. DATE OF DEATH Month <b>DEC.</b> Day <b>24</b> Year <b>1967</b>	
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>12-10-1884</b>
9. AGE (In years last birthday) <b>83</b> yrs.		IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>NO</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>BALTIMORE, MD.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>	
13. FATHER'S NAME <b>GEORGE KNELL</b>		14. MOTHER'S MAIDEN NAME <b>SOPHIE WISE</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>220-16-2963</b>	
17. INFORMANT <b>Records, Mt. Wilson State Hospital</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>4201</b> DUE TO <b>MYO PERICARDIUM &amp; TAMPONADE</b> (b) <b>RUPTURE OF L. VENTRICULAR MYOCARDIAL INFARCT</b> (c) <b>ARTEROSCLEROTIC HEART DISEASE</b>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <b>19</b> a.m. p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>P.B.</b>	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>11-13</b> , 19 <b>67</b> , to <b>12-24</b> , 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>12-24</b> 19 <b>67</b> , and that death occurred at <b>9:40 AM</b> , from causes and on the date stated above.			
22a. SIGNATURE <b>Wm. Newcomer</b>		22b. DATE SIGNED <b>12/24/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>Wm. Newcomer, M.D., Superintendent</b>		22d. ADDRESS <b>Mount Wilson, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE THEREOF <b>12/27/67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>ROCKY HILL CEM.</b>	23d. LOCATION (City or town) (County) (State) <b>FREDERICK COUNTY MD</b>
24. FUNERAL DIRECTOR <b>Cowell &amp; Fairley</b>		25a. REC'D BY REGISTRAR <b>WOODSBORO MD</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		DATE <b>DEC 28 1967</b>	

1243

1243

1243

1243

1243

1243



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

16437

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

16428

1 DECEASED NAME (Type or print) First Middle Last Dora Lindsay Ayres			2a. DATE OF DEATH Month Day Year Dec. 25, 1967		2b. HOUR M
3 SEX Female	4. RACE White	5. DATE OF BIRTH Nov. 24, 1917		6. AGE (In years lost birthday) 50 YRS	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (State or foreign country) Wil. Delaware	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Baltimore Md.		
10. CITY OR TOWN OF DEATH Pikesville	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 1018 Windsor Rd., Pikesville	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Housewife	12b. KIND OF BUSINESS OR INDUSTRY Own Home		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.	13b. COUNTY Baltimore	13c. CITY OR TOWN Pikesville	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER 1018 Windsor Rd., Pikesville	
14. FATHER'S NAME First Middle Last William Lindsay		15. MOTHER'S MAIDEN NAME First Middle Last Mary Starling			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) <input checked="" type="checkbox"/> NO		16b. SOCIAL SECURITY NO. (If yes give war or dates of service) None	17. INFORMANT Address Mrs. William J. Reed, 1018 Windsor Rd., Pikesville		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ACUTE CONGESTIVE HEART FAILURE</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>ARTERIOSCLEROTIC HEART DISEASE</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>BILATERAL BASILAR PNEUMONIA</u>					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)	21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <u>12-22-67</u> , to <u>12-23-67</u> , that (I) <del>was</del> last saw the deceased alive on <u>12-22-67</u> , and that in (my) <del>own</del> opinion death occurred on the date and hour and from the causes stated above, (I) <del>was</del> <del>(did)</del> (did not) view the body after death.					
22b. SIGNATURE <u>Samuel P. Scalia, MD</u>		22c. DATE SIGNED <u>12-27-67</u>	22d. PHYSICIAN'S NAME (Type) <u>SAMUEL P. SCALIA, MD</u>		
22e. ADDRESS <u>2 SHERRWOOD AVENUE PIKESVILLE, MD</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE <u>Dec. 27, 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Druid Ridge Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Pikesville Baltimore, Md.</u>		
24. FUNERAL DIRECTOR <u>Frank H. Newell, Pikesville, Md.</u>		25. REC'D BY REGISTRAR <u>Jan 4 1968</u>	26. REGISTRAR'S SIGNATURE <u>John H. Judge</u>		



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any is necessary, it should be directed to the Deputy Medical Examiner, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director for your files. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
SM 7/59

16433  
MORTON & DYETT F.H. 1701 Laurens Street

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TURNER STATION</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TURNER STATION</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>213 Center Street</u>		d. STREET ADDRESS <u>213 Center Street</u>	
3. NAME OF DECEASED (Type or print) <u>JOHN B. BANKS</u>		4. DATE OF DEATH Month <u>12</u> Day <u>26</u> Year <u>1967</u>	
5. SEX <u>M.</u>	6. COLOR OR RACE <u>N.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-5-1876</u>
9. AGE (In years last birthday) <u>91</u> yrs.		10. IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Beth-Steel</u>	
11. BIRTHPLACE (State or foreign country) <u>Dorchester Co., Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>ALEXANDER BANKS</u>		14. MOTHER'S MAIDEN NAME <u>MARTHA CORNISH</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war and dates of service) <u>216-09-6962</u>		17. INFORMANT Address <u>Mrs. Mary L. Banks 213 Center Street</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>acute coronary occlusion</u> <u>4201</u> DUE TO <u>HCVD</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) <u>  </u> (c) <u>  </u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I, a) <u>  </u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>  </u>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>  </u> p.m. <u>  </u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>  </u>	20f. (City or town) (County) (State) <u>  </u>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Theo C Patterson</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>THEO. C PATTERSON</u>		M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>12-30-67</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Arbutus Memorial Pk.</u>		22d. LOCATION (City, town, or country) (State) <u>Arbutus, Maryland</u>	
23. FUNERAL DIRECTOR <u>MORTON &amp; DYETT F.H. 1701 Laurens Street</u>		24a. REC'D BY REGISTRAR <u>DEC 28 1967</u>	
24b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		DATE SIGNED <u>12/24/67</u>	



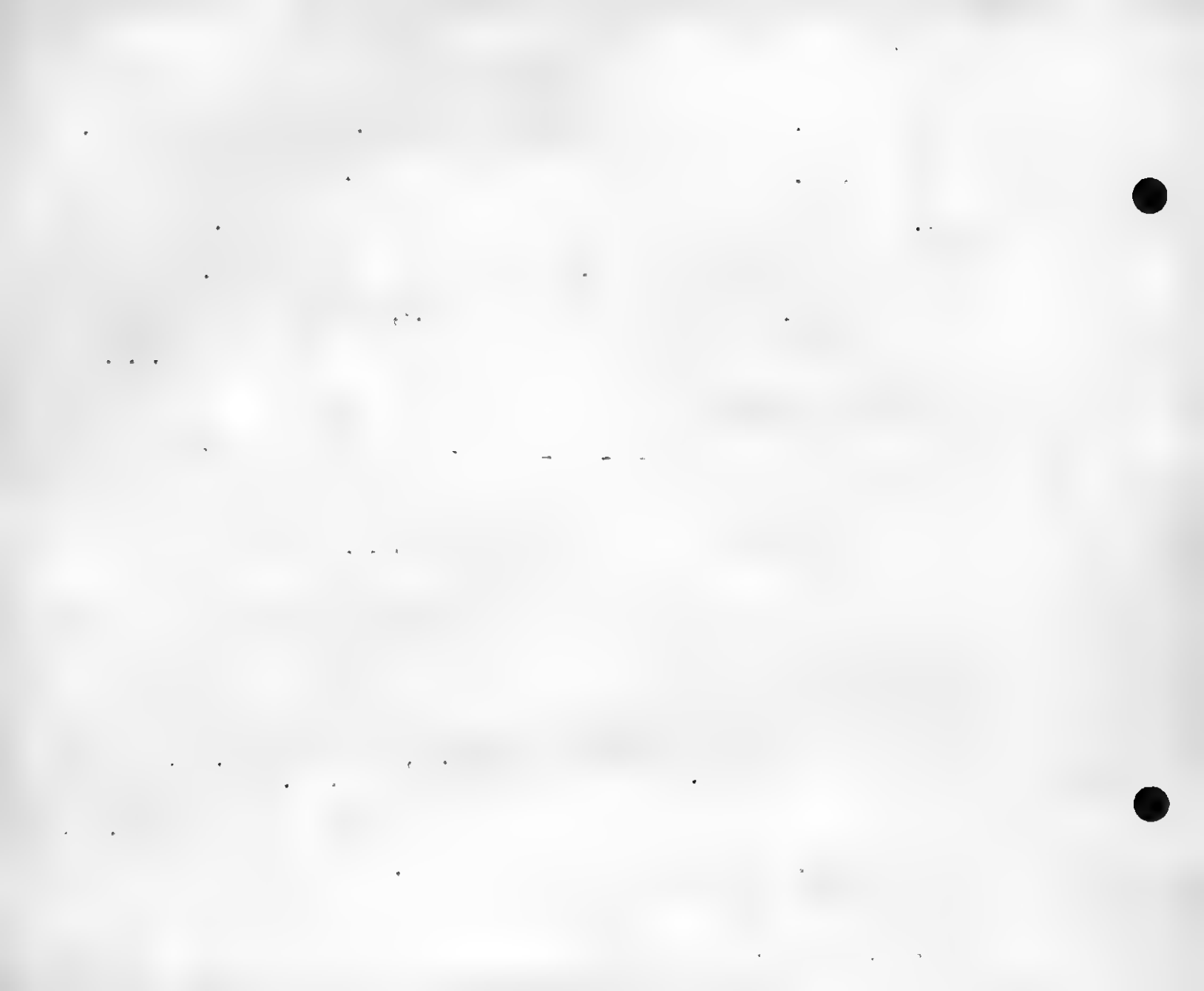
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1-and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

VR A15 (4)  
25M 1-67

<div style="text-align: center;"> <p>16439</p> <p>DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201</p> <p>CERTIFICATE OF DEATH</p> <p style="text-align: right;">15431</p> </div>											
1. PLACE OF DEATH a. COUNTY <b>BALTO.</b> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>MD.</b> b. COUNTY <b>Balto.</b>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Towson Md.</b>				c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Balto.</b>					
a. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>St. Joseph Hospital</b>						d. STREET ADDRESS <b>2308 Cider Mill Rd.</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Joseph H. Bartholme</b>						4. DATE OF DEATH Month <b>Dec.</b> Day <b>15</b> Year <b>1967</b>					
5. SEX <b>M</b>		6. COLOR OR RACE <b>W.</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Feb. 2, 1888</b>		9. AGE (In years last birthday) <b>79 yrs</b>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Farmer</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Germany</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Joseph A Bartholme</b>						14. MOTHER'S MAIDEN NAME <b>Barbara Schwartz</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>220-34-5478-A</b>		17. INFORMANT <b>Mrs Hattie J Bartholme</b>				Address <b>Same</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: <b>4</b> IMMEDIATE CAUSE (a) <b>Cardio Pulmonary Failure</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic C.V.D.</b> DUE TO (c)										INTERVAL BETWEEN ONSET AND DEATH	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>Nov. 5, 1967</b> to <b>Dec. 15, 1967</b> that (I) (we) lost saw the deceased alive on <b>Dec. 15, 1967</b> , and that death occurred of <b>8:15 p.m.</b> from causes and on the date stated above.											
22a. SIGNATURE <i>Benjamin del Carmen</i>						M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <b>Dec. 15, 1967</b>			
22c. PHYSICIAN'S NAME (Type) <b>Dr. Benjamin delCarmen</b>						22d. ADDRESS <b>St. Joseph Hospital</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>12/19/67</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Holy Redeemer</b>				23d. LOCATION (City or Town) (County) (State) <b>Baltimore Maryland</b>			
24. FUNERAL DIRECTOR <b>Leonard J Ruck Inc 5305 Harford Rd</b>						25a. REC'D BY REGISTRAR DATE <b>DEC 18 1967</b>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			

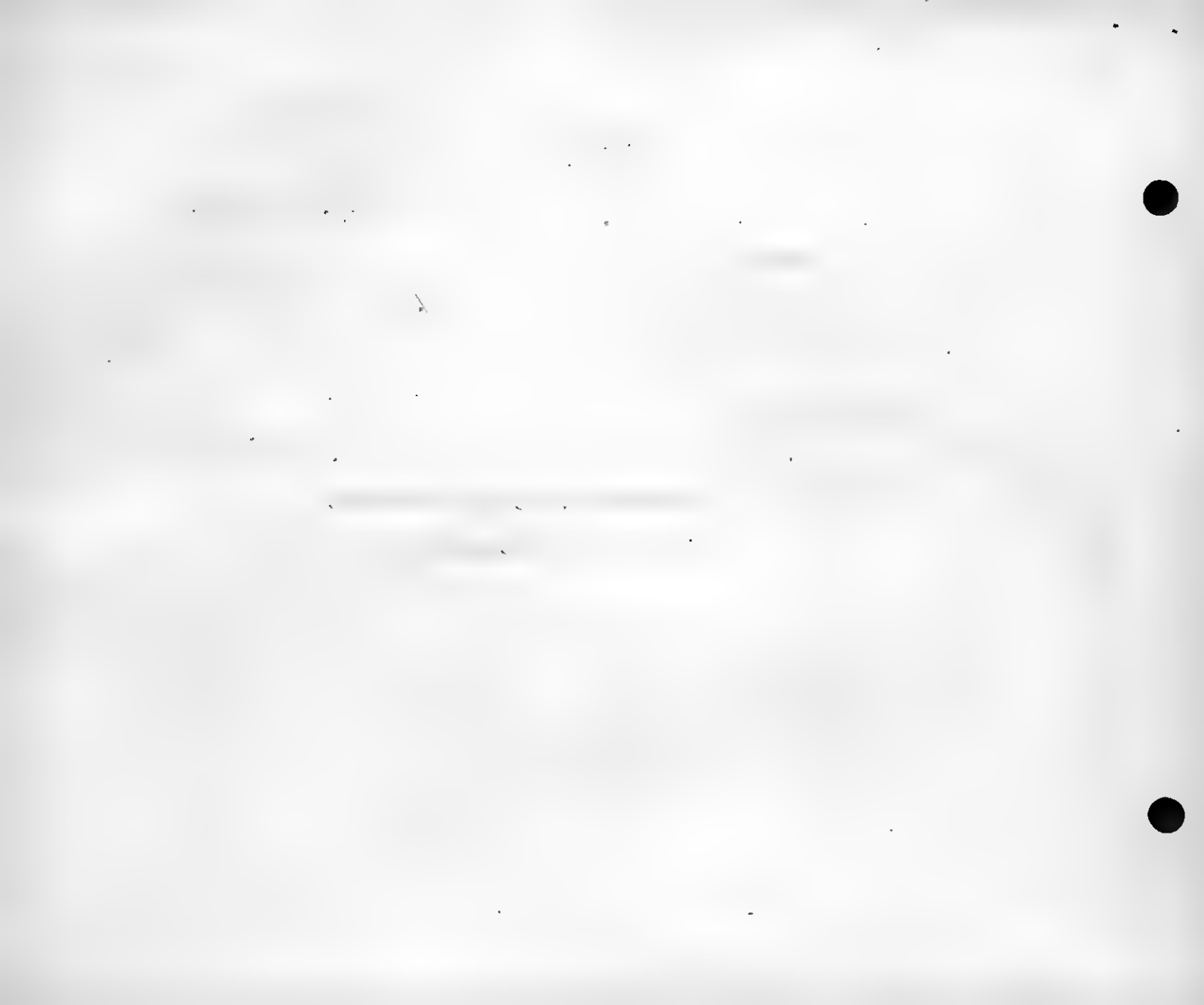




TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
16440  
16432  
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Pikesville</b> c. LENGTH OF STAY IN 1b <b>since 10/20/67</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Professional House, Inc.</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b></b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b> d. STREET ADDRESS <b>HIGHFIELD HOUSE, APT. 503 4000 N. Charles Street</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Joseph</b> Middle <b></b> Last <b>Beck</b>		4. DATE OF DEATH Month <b>12</b> Day <b>15</b> Year <b>1967</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>6/22/90</b>
9. AGE (In years last birthday) <b>77</b> yrs.		10. IF UNDER 1 YEAR Months <b></b> Days <b></b> Hours <b></b> Min. <b></b>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED</b>		12. KIND OF BUSINESS OR INDUSTRY <b>INVESTMENTS</b>	
13. FATHER'S NAME <b>Samuel Beck</b>		14. MOTHER'S MAIDEN NAME <b>Krieger, MOLIE LEAH</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>YES</b>		16. SOCIAL SECURITY NO. <b>W.W. I</b>	
17. INFORMANT <b>MRS. BLANCHE BECK, 4000 N. CHARLES ST., APT 503</b>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral vascular accident</b> 351X DUE TO <b>Severe arteriosclerosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b></b> DUE TO (c) <b></b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b></b>	
19. INTERVAL BETWEEN ONSET AND DEATH <b>days</b> <b>Un Known</b>		20. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
21c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m. <b></b>		21d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
21e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		21f. (City or town) (County) (State)	
21. I certify that (1) (this hospital) attended the deceased from <b>10-26</b> , 19 <b>67</b> , to <b>12-15</b> , 19 <b>67</b> , that (1) (we) last saw the deceased alive on <b>12-15</b> , 19 <b>67</b> , and that death occurred at <b>11:00</b> A.M. from the causes and on the date stated above.			
22a. SIGNATURE <b>David I. Miller</b>		22b. DATE SIGNED <b>12 15 67</b>	
22c. PHYSICIAN'S NAME (Type) <b>David I. Miller</b>		22d. ADDRESS <b>Union Pk. Co. Md</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>12-17-67</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>BALTIMORE HEBREW</b>		23d. LOCATION (City, town or county) (State) <b>BALTIMORE, MARYLAND</b>	
24. FUNERAL DIRECTOR <b>SOL LEVINSON &amp; BROS. INC., 6010 REISTERSTOWN ROAD</b>		25a. REC'D BY REGISTRAR <b>DEC 22 1967</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1644									
1643.1									
1 PLACE OF DEATH a COUNTY <b>BALTIMORE</b> MARYLAND					2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a STATE <b>Maryland</b> b COUNTY <b>Baltimore</b>				
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BALTIMORE</b>			c LENGTH OF STAY IN lb <b>11 days</b>		c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Timonium md. 21093</b>				
3 NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Greater Balts. Medical Center</b>					d STREET ADDRESS <b>131 Hollow Brooks Rd.</b>			e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) <b>Emma Anna Becker</b>					4 DATE OF DEATH Month <b>December</b> Day <b>3</b> Year <b>1967</b>				
5 SEX <b>Female</b>		6 COLOR OR RACE <b>Cau</b>		7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8 DATE OF BIRTH <b>11-09-84</b>		9 AGE (n years lost birthday) <b>83</b> yrs.	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>---</b>		11 BIRTHPLACE (County & State, or foreign country) <b>Baltimore Md.</b>		12 CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13 FATHER'S NAME <b>John Leivitz</b>					14 MOTHER'S MAIDEN NAME <b>Erinath</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>			16. SOCIAL SECURITY NO <b>212-05-7361</b>		17 INFORMANT <b>H. Chart</b> Address				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>443X Arterioarterial Cardiovascular disease</b> DUE TO (b) <b>Hypertension</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <b>29 years</b>									INTERVAL BETWEEN ONSET AND DEATH <b>29 years</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Mild Diabetes Mellitus</b>									19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)						
20c TIME OF INJURY Month, Day, Year Hour: a.m. <b>19</b> p.m.			20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <b>11/23</b> , 19 <b>67</b> , to <b>12/3</b> , 19 <b>67</b> , that (I) <del>was</del> <b>did</b> see the deceased alive on <b>12/3</b> , 19 <b>67</b> , and that death occurred at <b>2 A</b> M, from causes and on the date stated above.									
22a SIGNATURE <b>Derek H. Bruce</b>					M.D. ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED <b>12/3/67</b>		
22c. PHYSICIAN'S NAME (Type) <b>DEREK H. BRUCE</b>					22d ADDRESS <b>G. B. M. C.</b>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b DATE THEREOF <b>12-6-67</b>		23c NAME OF CEMETERY OR CREMATORY <b>Baltimore</b>			23d. LOCATION (City or Town) (County) (State) <b>Baltimore, Md.</b>		
24. FUNERAL DIRECTOR <b>Wm. Cook-Brooks Towson, 1050 York Rd.</b>					25a. REC'D BY REGISTRAR DATE <b>DEC 7 1967</b>		25b REGISTRAR'S SIGNATURE <b>Officer Judge</b>		



## CERTIFICATE OF DEATH

16434

16443

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 12 hours after death.

1 PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND			2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore, Maryland</b>		
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Towson 21204</b>		c LENGTH OF STAY IN 1b <b>8 mons</b>		c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore, Maryland 21206</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Dulaney Towson Nursing Home, 111 West</b>			d. STREET ADDRESS <b>5603 Rimmell Avenue</b>		
3 NAME OF DECEASED (Type or print) <b>Catherine Elizabeth Beilein</b>			4. DATE OF DEATH Month <b>December</b> Day <b>22</b> Year <b>1967</b>		
5 SEX <b>female</b>	6 COLOR OR RACE <b>white</b>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>August 10, 1889</b>		9 AGE (in years lost birthday) <b>78</b> YES <input type="checkbox"/> NO <input type="checkbox"/>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>Baltimore, Maryland</b>	
13. FATHER'S NAME <b>U. Thim</b>			14. MOTHER'S MAIDEN NAME <b>Catherine Eva Thim</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>		16 SOCIAL SECURITY NO <b>216-20-7168-1</b>		17. INFORMANT <b>Dulaney Towson Nursing Home, 111 West Road</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CIRCULATORY COLLAPSE</b> DUE TO <b>CEREBRAL MEMORIAL</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					INTERVAL BETWEEN ONSET AND DEATH <b>3 DAYS</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour <b>0.m.</b> p.m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <b>4/22, 1967</b> to <b>12/22, 1967</b> , that (I) (we) last saw the deceased alive on <b>12/20, 1967</b> , and that death occurred at <b>10 P.M.</b> from causes and on the date stated above.					
22a. SIGNATURE <b>T. C. Siwinski</b>			22b. DATE SIGNED <b>Dec. 22, 1967</b>		
22c. PHYSICIAN'S NAME (Type) <b>T. C. Siwinski, M.D.</b>			22d. ADDRESS <b>206 W. Penna. Ave., Towson, Maryland</b>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>12/26/67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Most Holy Redeemer</b>	23d. LOCATION (City or Town) (County) (State) <b>Baltimore Maryland</b>		
24. FUNERAL DIRECTOR <b>Leonard J Ruck Inc. 5305 Harford Rd</b>			25a. REC'D BY REGISTRAR <b>DATE DEC 27 1967</b>		25b. REGISTRAR'S SIGNATURE



•

•

•

• • •

•

•

•

•

•

•

•

•

•





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1644

16435

1 PLACE OF DEATH a. COUNTY <b>BALTO.</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>MD.</b> b. COUNTY <b>BALTO</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>ESSEX</b>		c. LENGTH OF STAY IN 1b <b>03-1</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>117 HALL NURSING HOME</b>		d. STREET ADDRESS <b>7910 BRIDGE</b>	
3 NAME OF DECEASED (Type or print) <b>EDWARD BERK</b>		4 DATE OF DEATH Month <b>DEC</b> Day <b>31</b> Year <b>1967</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>8/28/86</b>
9. AGE (In years last birthday) <b>81 yrs</b>		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>MACHINIST</b>		12. KIND OF BUSINESS OR INDUSTRY <b>BALTO. MD.</b>	
13. FATHER'S NAME <b>GEORGE BERK</b>		14. MOTHER'S MAIDEN NAME <b>P</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>UNK</b>		16. SOCIAL SECURITY NO. <b>219-16-7054</b>	
17. INFORMANT <b>AGNES SHEELER</b>		Address <b>RTE 16 BOX 487-17</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> <b>4201</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>ASCVD with Myocard</b> DUE TO (c) <b>Chronic Emphysema</b>		INTERVAL BETWEEN ONSET AND DEATH <b>5 yrs</b>	
PART II: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1B)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Jan 1, 1964</b> to <b>Dec 31, 1967</b> that (I) (we) last saw the deceased alive on <b>Dec 31, 1967</b> , and that death occurred at <b>M</b> , from causes and on the date stated above			
22a. SIGNATURE <b>C. M. BEUMGARDNER</b> M.D.		22b. DATE SIGNED <b>1/3/68</b>	
22c. PHYSICIAN'S NAME (Type) <b>C. M. BEUMGARDNER</b>		22d. ADDRESS <b>BALTO 21237</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE THEREOF <b>1/4/68</b>	23c. NAME OF CEMETERY OR CREMATORY <b>SACRED HEART</b>	23d. LOCATION (City or Town) (County) (State) <b>BALTO. MD.</b>
24. FUNERAL DIRECTOR <b>J. J. CONNELLY SONS</b>		25a. REGD. BY REGISTRAR <b>JAN 5 1968</b>	
ADDRESS <b>300 MACC</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers and return them to the funeral director. Page 4 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

VR A15 (4)  
25M 1/67

16444				DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				16436			
CERTIFICATE OF DEATH											
1 PLACE OF DEATH a. COUNTY <u>Balto.</u> MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if institut on Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u></u>							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RANDALLS TOWN</u>				c. LENGTH OF STAY IN TB				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>BALTO. County General</u>				d. STREET ADDRESS <u>3604 Greenmount Ave.</u>				# IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3 NAME OF DECEASED (Type or print) <u>ALBERT R BEVANS</u>				4 DATE OF DEATH Month <u>12</u> Day <u>1</u> Year <u>1967</u>							
5. SEX <u>Male</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>10-22-00</u>		9. AGE (In years last birthday) <u>67</u> yrs		IF UNDER 1 YEAR Months <u></u> Days <u></u> Hours <u></u> Min <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Sales</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Cloverland Dairy</u>				11. BIRTHPLACE (County & State or foreign country) <u>BALTO. Md.</u>			
13. FATHER'S NAME <u>John H. Bevans</u>				14. MOTHER'S MAIDEN NAME <u>Julia A. Bayne</u>				12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>UNKNOWN</u>				16. SOCIAL SECURITY NO <u>25-10-8115</u>		17. INFORMANT <u>Eva Bevans</u>		Address <u>Same.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Respiratory Insufficiency</u> DUE TO <u>350 x</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Pulmonary Embolism, Bronchopneumonia</u> DUE TO <u>Parotitis</u> (c) <u>5011511</u>								INTERVAL BETWEEN ONSET AND DEATH			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1B)							
20c. TIME OF INJURY Month, Day, Year Hour <u>a.m.</u> p.m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>12/1/67</u> , 19 <u>67</u> , to <u>12/1/67</u> , 19 <u>67</u> , that (I) ( <u>was</u> ) lost saw the deceased alive on <u>12/1/67</u> , 19 <u>67</u> , and that death occurred at <u>7:01 P.</u> M, from causes and on the date stated above.											
22a. SIGNATURE <u>Elliott Michelson</u>				M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED <u>12/1/67</u>					
22c. PHYSICIAN'S NAME (Type) <u>Elliott Michelson</u>				22d. ADDRESS <u>1801 Eutaw Place Bk 41217</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>12/4/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Parkwood Cem.</u>				23d. LOCATION (City or town) (County) (State) <u>Balto. Md.</u>			
24. FUNERAL DIRECTOR <u>Leonard J. Ruck Inc. Balto. Md.</u>				ADDRESS		25a. REC'D BY REGISTRAR <u>DEC 5 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1 PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND						2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>CARROLL</b>					
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FORT HOWARD</b>				c LENGTH OF STAY IN 1b <b>30 DAYS</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>WESTMINISTER</b>					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>VETERANS ADMINISTRATION HOSPITAL</b>						d STREET ADDRESS <b>RD #6</b>				e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>AUGUSTUS WINFIELD BITZEL</b>						4. DATE OF DEATH Month Day Year <b>DECEMBER 9, 19 67</b>					
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>11/4/95</b>		9. AGE (In years last birthday) yrs. <b>72</b>		IF UNDER 1 YEAR Months Days Hours Min	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>farmer also worked in</b>				10b KIND OF BUSINESS OR INDUSTRY <b>distillery</b>		11 BIRTHPLACE (County & State, or foreign country) <b>CARROLL COUNTY, MARYLAND</b>				12 CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>CHARLES H. BITZEL</b>						14. MOTHER'S MAIDEN NAME <b>ELIZABETH CROOKS</b>					
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>YES WWI</b>				16 SOCIAL SECURITY NO <b>213-12-6593</b>		17 INFORMANT Address <b>CLINICAL RECORDS, VAH, FT. HOWARD, MD.</b>					
18. CAUSE OF DEATH (Enter on any one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <b>BRONCHO-PNEUMONIA</b> <b>4 2 2 1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>---</b> DUE TO (c) <b>ARTERIOSCLEROTIC CADRIOVASCULAR DISEASE</b>										INTERVAL BETWEEN ONSET AND DEATH <b>DAYS</b>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>DIABETES MELLITUS, ARTERIOSCLEROTIC OBLITERANS LEGS</b>										19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>				20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)			
21. I certify that <b>Dr</b> (this hospital) attended the deceased from <b>NOV 9, 19 67</b> , to <b>DEC 9, 19 67</b> , that <b>(x)</b> (we) last saw the deceased alive on <b>DEC 9, 19 67</b> , and that death occurred at <b>6:05A</b> M, from causes and on the date stated above											
22a. SIGNATURE <b>Chong Choon Han MD</b>						ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22b. DATE SIGNED <b>12/9/67</b>			
22c. PHYSICIAN'S NAME (Type) <b>CHONG CHOON HAN</b>						22d. ADDRESS <b>VAH, FORT HOWARD, MARYLAND</b>					
23a BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b DATE THEREOF <b>12/12/67</b>		23c NAME OF CEMETERY OR CREMATORY <b>TRINITY LUTHERAN CEM.</b>				23d LOCATION (City or Town) (County) (State) <b>FINKSBURG, MD. CARROLL Co.</b>			
24. FUNERAL DIRECTOR <b>MYERS FUNERAL HOME WESTMINSTER, MD.</b>						25a. REC'D BY REGISTRAR <b>DEC 12 1967</b>		25b REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>			





**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201**

**CERTIFICATE OF DEATH**

16446

16438

1 PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) o STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>			
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b>			c LENGTH OF STAY IN 1b <b>9 days</b>		c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>		
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Veterans Administration Hospital</b>				d STREET ADDRESS <b>Box 394 Rt 16</b>		e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First <b>ROY</b> Middle <b>WREATH</b> Last <b>BLANTON</b>				4 DATE OF DEATH Month <b>Dec.</b> Day <b>27</b> Year <b>19 67</b>			
5 SEX <b>Male</b>	6 COLOR OR RACE <b>White</b>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>10/5/92</b>		9 AGE (In years last birthday) <b>75</b> yrs	IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS Months Days Hours Min
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Mechanic</b>		10b KIND OF BUSINESS OR INDUSTRY <b>Aircraft Co.</b>		11 BIRTHPLACE (County & State, or foreign country) <b>Cherokee, S.C.</b>		12 CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Andrew P. Blanton</b>				14. MOTHER'S MAIDEN NAME <b>Mossie E. Vinesett</b>			
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>Yes WW-1</b>		16 SOCIAL SECURITY NO <b>240 07 90 40</b>		17 INFORMANT Address <b>Clinical Recds, VA Hospital, Fort Howard Md.</b>			
18 CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>CEREBRAL THROMBOSIS</b> <b>332 X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost } (b) <b>CEREBRAL ARTERIOSCLEROSIS</b> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>BRONCHOPNEUMONIA</b>							19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e PLACE OF INJURY (Home, farm, factory, street, office bldg, etc)		20f (City or town) (County) (State)	
21. I certify that <del>Dr</del> (this hospital) attended the deceased from <b>Dec. 1</b> , 19 <b>67</b> to <b>Dec. 27</b> , 19 <b>67</b> , that <del>he</del> (we) last saw the deceased alive on <b>Dec. 27</b> , 19 <b>67</b> , and that death occurred at <b>1:15 PM</b> , from causes and on the date stated above							
22a SIGNATURE <i>John D. Talbert</i>				P.M. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b DATE SIGNED <b>12/27/67</b>	
22c PHYSICIAN'S NAME (Type) <b>JOHN D. TALBERT, M.D.</b>				22d ADDRESS <b>VA Hospital, Fort Howard, Md.</b>			
23a BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b DATE THEREOF <b>12/30/67</b>		23c NAME OF CEMETERY OR CREMATORY <b>Belair Memorial Gardens</b>		23d LOCATION (City or Town) (County) (State) <b>Baltimore Maryland</b>	
24 FUNERAL DIRECTOR <b>Connelly Funeral Home</b>				25a REC'D BY REGISTRAR <b>Essex, Md.</b>		25b REGISTRAR'S SIGNATURE <b>DATE JAN 2 1968</b>	

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.



1644

CERTIFICATE OF DEATH

16439

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Owings Mills</b>		c. LENGTH OF STAY IN 1b <b>45 yrs.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Rosewood State Hospital</b>		d. STREET ADDRESS <b>842 Konig Street</b>	
3. NAME OF DECEASED (Type or print) First <b>Anna</b> Middle <b>-</b> Last <b>BOBROFSKY</b>		4. DATE OF DEATH Month <b>12</b> Day <b>20</b> Year <b>19 67</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1-15-10</b>
9. AGE (n years last birthday) <b>57</b> yrs		10. IF UNDER 1 YEAR Months <b>12</b> Days <b>20</b> Hours <b>19</b> Min <b>67</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Dependent</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>none</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Baltimore City, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Israel Bobrofsky</b>		14. MOTHER'S MAIDEN NAME <b>Lena Friedman</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO <b>none</b>	
17. INFORMANT <b>Rosewood Records, Owings Mills, Maryland</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Myocardial infarction</b> DUE TO (b) <b>Arterial Sclerotic Coronary Vascular</b> DUE TO (c) <b>Disease with Thrombosis</b>		INTERVAL BETWEEN ONSET AND DEATH <b>terminal</b> <b>years</b> <b>terminal</b>	
PART II: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (if this hospital) attended the deceased from <b>1/16</b> , 19 <b>67</b> , to <b>12/20</b> , 19 <b>67</b> , that (if we) last saw the deceased alive on <b>12/20</b> , 19 <b>67</b> , and that death occurred at <b>8:05</b> <b>PM</b> on the date stated above.			
22a. SIGNATURE <b>Richard A. Jones</b>		22b. DATE SIGNED <b>12/20/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>Richard A. Jones, M.D.</b>		22d. ADDRESS <b>Rosewood St. Hosp., Owings Mills, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>12/22/1967</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Rosewood Hospital Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Owings Mills, Md</b>	
24. FUNERAL DIRECTOR <b>Seymour Lewis and GALT</b>		25a. REC'D BY REGISTRAR <b>DEC 26 1967</b>	
25b. REGISTRAR'S SIGNATURE <b>James J. Jones</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

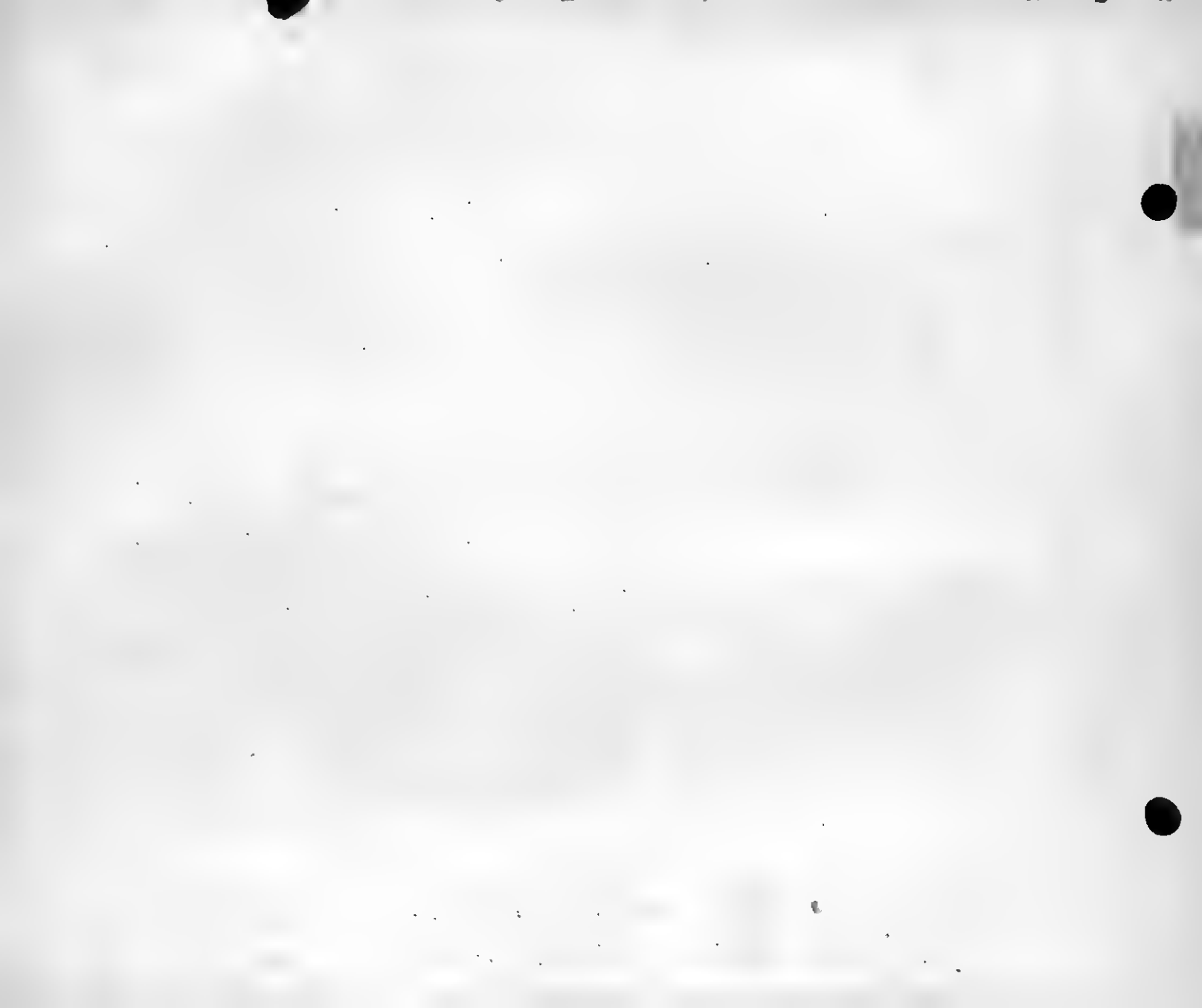
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 2 and 3, and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH																	
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND																	
16445 CERTIFICATE OF DEATH 13440																	
1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>GREATER BALTIMORE</b> c. LENGTH OF STAY IN 1b <b>2, fe</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Greater Baltimore Medical Center.</b>						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>BALTIMORE</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore, Md</b> d. STREET ADDRESS <b>6701 North Charles</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>											
3. NAME OF DECEASED (Type or print) First <b>MARY</b> Middle <b>DOROTHY</b> Last <b>Bohenberg</b>			4. DATE OF DEATH Month <b>12</b> Day <b>5</b> Year <b>1968</b>			5. SEX <b>FEMALE</b>			6. COLOR OR RACE <b>W</b>			7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDED <input type="checkbox"/> DIVORCED <input type="checkbox"/>					
8. DATE OF BIRTH <b>12-5-1918</b>			9. AGE (In years last birthday) <b>50</b> yrs. IF UNDER 1 YEAR Months Days Hours Min.			10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Cashier</b>			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (County & State, or foreign country) <b>BALTIMORE Md.</b>					
12. CITIZEN OF WHAT COUNTRY?						13. FATHER'S NAME <b>John Popp</b>						14. MOTHER'S MAIDEN NAME <b>Smith</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)						16. SOCIAL SECURITY NO. <b>215-10-3398</b>						17. INFORMANT <b>Admission Sheet</b> Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Circulatory collapse due to</b> <b>1750</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Hypertensive metastases fr.</b> (c) <b>Carcinoma of the ovary</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)																	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>																	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)																	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)																	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from <b>11-17, 1967</b> to <b>12-5, 1967</b> , that (I) (we) last saw the deceased alive on <b>12-5 - 1967</b> , and that death occurred at <b>5:30</b> P.M. from the causes and on the date stated above.																	
22a. SIGNATURE <b>J. J. J.</b>																	
22b. DATE SIGNED <b>12-5-67</b>																	
22c. PHYSICIAN'S NAME (Type)						22d. ADDRESS <b>GBMC</b>											
23a. BURIAL, CREMATION, REMOVAL (Specify)				23b. DATE THEREOF <b>12/9/67</b>				23c. NAME OF CEMETERY OR CREMATORY <b>Lawson of Faith</b>				23d. LOCATION (City, town or county) (State) <b>Baltimore</b>					
24. FUNERAL DIRECTOR <b>Philip H. H. H.</b> ADDRESS <b>2024 Calver St</b>																	
25a. REC'D BY REGISTRAR <b>DEC 8 1967</b>																	
25b. REGISTRAR'S SIGNATURE <b>Charles J. J.</b>																	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

16449

16441

1 PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b>		c. LENGTH OF STAY IN 1b <b>33 Days</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Veterans Administration Hospital</b>		e. STREET ADDRESS <b>7151 Eastbrook Avenue</b>	
3 NAME OF DECEASED (Type or print) First Middle Last <b>JOSEPH WALTER BOLGER</b>		4. DATE OF DEATH Month Day Year <b>DECEMBER 16 19 67</b>	
5 SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>2/16/18</b>
9 AGE (In years last birthday) <b>49 yrs</b>		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Cutter</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Clothing</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Baltimore, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John Bolger</b>		14. MOTHER'S MAIDEN NAME <b>Eva Kieltyka</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>Yes WWII</b>		16. SOCIAL SECURITY NO <b>216-07-0868</b>	
17. INFORMANT <b>Clin. Rec. VA Hospital, Fort Howard, Maryland</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <b>CARCINOMA OF LARYNX</b> <b>161X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>METASTATIC CARCINOMA BOTH SIDES OF NECK</b> DUE TO (c)			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVA. BETWEEN ONSET AND DEATH <b>YEARS</b> <b>MONTHS</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <b>JOE</b> (this hospital) attended the deceased from <b>November 13 19 67</b> , to <b>December 16 19 67</b> , that <b>he</b> (we) last saw the deceased alive on <b>December 16 19 67</b> , and that death occurred at <b>9:25 AM</b> , from causes and on the date stated above.			
22a. SIGNATURE <b>Rodolfo G. Miro, M.D.</b>		22b. DATE SIGNED <b>12/16/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>RODOLFO G. MIRO, M.D.</b>		22d. ADDRESS <b>VA HOSPITAL, FORT HOWARD, MARYLAND</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>12/20/67</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Baltimore, Maryland</b>	
24. FUNERAL DIRECTOR <b>John M. Weber &amp; Sons Inc.</b>		25a. REC'D BY REGISTRAR <b>DEC 18 1967</b>	
25b. REGISTRAR'S SIGNATURE <b>John M. Weber &amp; Sons Inc.</b>		25c. REGISTRAR'S SIGNATURE <b>John M. Weber &amp; Sons Inc.</b>	



1 2 3

4 5 6 7 8

9



10 11 12

13

14

15

16

17

18



# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (3)  
6M 1/67

16450

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

16443

1 PLACE OF DEATH a COUNTY <b>BALTIMORE</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a STATE <b>MARYLAND</b> b COUNTY	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>TOWSON</b>		c LENGTH OF STAY IN TB <b>BALTIMORE (Hamilton)</b>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>7620 YORK H ROAD ST. JOSEPH HOSP.</b>		d STREET ADDRESS <b>7011 ARION AVE</b>	
3 NAME OF DECEASED (Type or print) <b>HOWARD R. BOWEN</b>		4 DATE OF DEATH Month <b>12</b> - Day <b>8</b> - Year <b>67</b>	
5. SEX <b>MALE</b>	6 COLOR OR RACE <b>WHITE</b>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>1-14-05</b>
9 AGE (In years last birthday) <b>62</b> yrs		IF UNDER 1 YEAR: Months <b>19</b> Days <b>19</b> Hours <b>19</b> Min <b>19</b>	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>ELECT. MAINTENANCE</b>		10b KIND OF BUSINESS OR INDUSTRY <b>MARTIN CO.</b>	
11 BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		2 CITIZEN OF WHAT COUNTRY <b>USA</b>	
13 FATHER'S NAME <b>HOWARD R. BOWEN</b>		14 MOTHER'S MAIDEN NAME <b>JEANIE ROSS</b>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>NO</b>		16 SOCIAL SECURITY NO <b>218013301</b>	
17 INFORMANT <b>BESSIE BOWEN, 7011 ARION AVE. 21234</b>		Address	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion Sudden</b> DUE TO (b) <b>Emphysema</b> DUE TO (c) <b>2 yr</b>			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.	20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Charles F. O'Donnell</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>Charles F. O'Donnell, M.D.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
		Address (Street city town or county)	
23a BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b DATE THEREOF <b>12-11-67</b>	23c NAME OF CEMETERY OR CREMATORY <b>LORRAINE PARK CEMETERY</b>	23d LOCATION (City or Town) (County) (State) <b>BALTIMORE, MD.</b>
24. FUNERAL DIRECTOR <b>HOWARD H. HUBBARD 4107 WILKENS AVE., 21229</b>		25a REC'D BY REG STRAR <b>DEC 12 1967</b>	
		25b REG STRAR'S SIGNATURE <b>J. Charles Judge</b>	



MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

16451

16443

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Towson</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore 21207</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Chesapeake Manor Nursing Home</b>		d. STREET ADDRESS <b>3910 Milford Ave.</b>	
3. NAME OF DECEASED (Type or print) <b>Hilda M. Brady</b>		4. DATE OF DEATH Month <b>Dec.</b> Day <b>27</b> Year <b>1967</b>	
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3/24/1891</b>
9. AGE (in years last birthday) <b>76</b> yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Homemaker</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Baltimore, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Eli Free Matthews</b>		14. MOTHER'S MAIDEN NAME <b>Barbara Ellen Sparwasser</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>442-01-1620B</b>	
17. INFORMANT <b>305 Princeton Blvd.</b>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Broncho. pneumonia</b> DUE TO (b) <b>Arterio-Sclerotic Heart Disease</b> DUE TO (c) <b>Cerebral Thrombosis</b>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <b>5 days</b> <b>2 yrs</b> <b>6 months</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Generalized Arterio-Sclerosis</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <b>None</b>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>Aug. 29, 1959</b> to <b>Dec. 27, 1967</b> , that (I) (we) last saw the deceased alive on <b>Dec. 27, 1967</b> , and that death occurred at <b>10:00 P.M.</b> from causes and on the date stated above.			
22a. SIGNATURE <b>Earl L. Chambers</b>		22b. DATE SIGNED <b>12/29/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>Dr. Earl Chambers</b>		22d. ADDRESS <b>4108 Liberty Hghts. Ave.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>12/30/67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Druid Ridge</b>	23d. LOCATION (City or Town) (County) (State) <b>Pikesville, Balto. Co. Md.</b>
24. FUNERAL DIRECTOR <b>H.W. Jenkins &amp; Sons Co.</b>		25a. REC'D BY REGISTRAR <b>JAN 2 1968</b>	25b. REGISTRAR'S SIGNATURE <b>J. W. Jenkins</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (pages 1 and 2) and file with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

16452

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

13444

1 PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. LENGTH OF STAY IN 1b <b>Catonsville</b> Arbutus	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Summit Nursing Home</b>		d. STREET ADDRESS <b>4502 Leeds Ave., 21229</b>	
3 NAME OF DECEASED (Type or print) <b>HENRIETTA H. BRAUN</b>		4 DATE OF DEATH Month <b>Dec</b> Day <b>21</b> Year <b>1967</b>	
5 SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>9/23/91</b>
9 AGE (In years lost birthday) <b>76</b> yrs		10 IF UNDER 1 YEAR Months <b>21</b> Days <b>19</b> Hours <b>67</b> Min	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Self Employed</b>		11b. KIND OF BUSINESS OR INDUSTRY <b>Retired</b>	
12 CITIZEN OF WHAT COUNTRY? <b>USA</b>		13 FATHER'S NAME <b>Cart Trebess</b>	
14 MOTHER'S MAIDEN NAME <b>Emma V. Thomas</b>		15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>	
16 SOCIAL SECURITY NO <b>215-10-3182</b>		17 INFORMANT <b>Mr. Walter H. Braun, Jr., 1111 Dorchester Ave</b>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Transitional Carcinoma bladder</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>—</b> DUE TO (c) <b>—</b>		INTERVAL BETWEEN ONSET AND DEATH <b>1 yr</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF OTHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour <b>0</b> m <b>19</b> p m	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>Sept 1966</b> to <b>Dec 21, 1967</b> , that (I) (we) last saw the deceased alive on <b>12-19-1967</b> , and that death occurred <b>4:57 A.M.</b> from causes on and on the date stated above			
22a. SIGNATURE <b>Earl I. Pass</b>		22b. DATE SIGNED <b>12-21-67</b>	
22c. PHYSICIAN'S NAME (Type) <b>Earl I. Pass</b>		22d. ADDRESS <b>4001 Wilkens Ave., Baltimore, Md. 21229</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>12/23/67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Loudon Park Cemetery</b>	23d. LOCATION (City or Town) (County) (State) <b>Baltimore Md.</b>
24 FUNERAL DIRECTOR <b>Howard H. Hubbard, 4107 Wilkens Ave. 21229</b>		25a. RECEIVED BY REGISTRAR <b>DEC 26 1967</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

VR A15 (4)  
25M 1/67

72-12-

more, bM, 910m1-

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1 PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>		c. LENGTH OF STAY IN TB <u>1MTH 8DYS</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Spring Grove State Hospital</u>		d. STREET ADDRESS <u>4202 53rd Avenue</u>	
3. NAME OF DECEASED (Type or print) <u>Robert Milton Brickerd</u>		4. DATE OF DEATH Month <u>December</u> Day <u>8</u> Year <u>19 67</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>10/24/30</u>
9. AGE (In years last birthday) <u>36</u> yrs		10. IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Plumber, unemployed</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>  </u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Charles Brickerd</u>		14. MOTHER'S MAIDEN NAME <u>Ethel M. Harvey</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>578 40 6466</u>	
17. INFORMANT <u>Records: Spring Grove State Hospital</u>		Address <u>  </u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: <u>1939</u> IMMEDIATE CAUSE (a) <u>ASTROCYTOMA, Grade 3 or 4.</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) <u>  </u> DUE TO (c) <u>  </u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <u>  </u>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>  </u> p.m. <u>  </u> 19 <u>  </u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>  </u>	20f. (City or town) (County) (State) <u>  </u>
21. I certify that <u>  </u> (this hospital) attended the deceased from <u>10/30</u> , 19 <u>67</u> to <u>12-8</u> , 19 <u>67</u> , and that death occurred at <u>3:45</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>Anthony J. Young, M.D.</u>		22b. DATE SIGNED <u>12-8-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Anthony J. Young, M.D.</u>		22d. ADDRESS <u>Spring Grove State Hospital</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>Dec 11, 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Ft Lincoln Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Colmar Manor Pro Geo Md.</u>
24. FUNERAL DIRECTOR <u>F. Gasch's Sons Hyattsville, Md.</u>		25a. REC'D BY REGISTRAR <u>  </u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		DATE <u>DEC 11 1967</u>	

1645

16445

1 1



1 1

1

1

1

1



1 1 1

1



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (pages 1 and 2) should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 12 hours after death.

VR A15  
20 M 1/66

<div> <div>16454</div> <div>         Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201          100-5-1 &amp; 6 FILM 03.7 12/20/51 KK  <b>CERTIFICATE OF DEATH</b> </div> <div>16446</div> </div>											
<b>1. PLACE OF DEATH</b> a. COUNTY <u>BALTIMORE</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CATONSVILLE</u> c. LENGTH OF STAY IN TB d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>SUMMIT CONV. HOME</u>						<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institut on Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY c. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <u>CATONSVILLE MD</u> d. STREET ADDRESS <u>5717 EDMONDSON AVE</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
<b>3. NAME OF DECEASED</b> (Type or print) <u>EDWARD</u> First <u>H</u> Middle <u>BROWN</u> Last <b>4. DATE OF DEATH</b> <u>DEC</u> Month <u>7</u> Day <u>19</u> Year <u>67</u>						<b>5. SEX</b> <u>Male</u> <b>6. COLOR OR RACE</b> <u>White</u> <b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> <b>8. DATE OF BIRTH</b> <u>8-27-1881</u> <b>9. AGE</b> (In years last birthday) <u>86</u> yrs. <b>10. IF UNDER 1 YEAR</b> Months Days <b>11. IF UNDER 24 HRS</b> Hours Min.					
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>BLACKSMITH</u> <b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>11. BIRTHPLACE</b> (County & State or foreign country) <u>MARYLAND</u> <b>12. CITIZEN OF WHAT COUNTRY?</b> <u>USA</u>				<b>13. FATHER'S NAME</b> <u>GEORGE BROWN</u> <b>14. MOTHER'S MAIDEN NAME</b> <u>ELIZABETH SHELBY</u>							
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>NO</u> (If yes give war or dates of service) <b>16. SOCIAL SECURITY NO.</b> <u>1</u> <b>17. INFORMANT</b> Address											
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CHRONIC SIGNIFICANT CORONARY</u> <u>1000</u> DUE TO <u>RESULTING FROM</u> Conditions if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>ARTERIO-SCLEROTIC CHANGES - VASCULAR</u> DUE TO (c) <u>DIABETES</u>											
<b>PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)</b>										<b>19. WAS A TOLPS PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <b>20b. DESCRIBE HOW INJURY OCCURRED</b> (Enter nature of injury in Part I or Part II of item 18.) <b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. p.m. <u>19</u> <b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <b>20f. (City or town) (County) (State)</b>											
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>1/1</u> , 19 <u>62</u> , to <u>12/7</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>12/7</u> , 19 <u>67</u> , and that death occurred at <u>7:00 PM</u> , from causes and on the date stated above.											
<b>22a. SIGNATURE</b> <u>John H. S. S. M.D.</u> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> <b>22c. PHYSICIAN'S NAME (Type)</b> <u>John H. S. S. M.D.</u>						<b>22b. DATE SIGNED</b> <u>12/7/67</u> <b>22d. ADDRESS</b> <u>5717 EDMONDSON AVE. CATONSVILLE MD</u>					
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>CATONSVILLE</u> <b>23b. DATE THEREOF</b> <u>12/9/67</u> <b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>LORRAINE PARK</u> <b>23d. LOCATION (City or Town) (County) (State)</b> <u>BALTO MD</u>				<b>24. FUNERAL DIRECTOR</b> <u>WEBER FUNERAL HOME</u> ADDRESS <u>5311 EDMONDSON AVE</u> <b>25a. REC'D BY REGISTRAR</b> <u>DEC 8</u> <b>25b. REGISTRAR'S SIGNATURE</b> <u>Charles Judge</u>							



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1 PLACE OF DEATH a COUNTY <b>Baltimore</b> b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Mount Wilson</b> c LENGTH OF STAY IN 1b <b>2 mos. 8 days</b>						2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a STATE <b>MARYLAND</b> b COUNTY <b>PRINCE GEORGES</b> c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>LAUREL</b>					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Mount Wilson State Hospital</b>						d STREET ADDRESS <b>809 WEST STREET.</b> e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <b>JAMES ALFRED BROWN</b> First Middle Last						4. DATE OF DEATH <b>12 / 26 / 1967</b> Month Day Year					
5 SEX <b>M.</b>		6. COLOR OR RACE <b>C</b>		7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>4, 24, 1913</b> Yrs		9. AGE (in years lost birthday) <b>54</b> Months Days Hours Min		12 CITIZEN OF WHAT COUNTRY? <b>USA.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>JANITOR</b>				10b. KIND OF BUSINESS OR INDUSTRY				11 BIRTHPLACE (County & State, or foreign country) <b>SILVER SPRING, MD.</b>			
13. FATHER'S NAME <b>ULYSSES BROWN</b>						14. MOTHER'S MAIDEN NAME <b>SARAH WARNER.</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)				16 SOCIAL SECURITY NO <b>214-28-9876</b>		17 INFORMANT <b>Records, Mt. Wilson State Hospital</b> Address					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Respiratory insufficiency</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>Pneumonitis, terminal, staphylococcal</b> DUE TO (c) <b>Ca of the lung, Lt, squamous cell.</b>										INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Pulmonary Tuberculosis.</b>										19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>				20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>10 / 18 / 1967</b> to <b>12 / 26 / 1967</b> , that (I) (we) last saw the deceased alive on <b>12 / 26 / 1967</b> , and that death occurred at <b>6:00 PM</b> , from causes and on the date stated above.											
22a. SIGNATURE <b>W. Newcomer</b>						MD. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22b DATE SIGNED	
22c. PHYSICIAN'S NAME (Print) <b>Wm. Newcomer, M.D., Superintendent</b>						22d. ADDRESS <b>Mount Wilson, Maryland</b>					
23a BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b DATE THEREOF <b>1/2/68</b>		23c NAME OF CEMETERY OR CREMATORY <b>Asbury Cemetery</b>				23d LOCATION (City or Town) (County) (State) <b>Bacontown, Md.</b>			
24. FUNERAL DIRECTOR <b>George R. Snowden</b>						ADDRESS <b>Rockville, Md.</b>		25a. REC'D BY REGISTRAR <b>JAN 2 1968</b>		25b REGISTRAR'S SIGNATURE <b>James Judge</b>	



# FOR STATE HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
6M 1/67

## MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

### MEDICAL EXAMINER'S CERTIFICATE OF DEATH

16456		16448	
1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Garrison c. LENGTH OF STAY IN 1b 1 yr		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson 4	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Resurrection Road at Valley Rd		d. STREET ADDRESS 1417 Jeffers, Rd.	
3. NAME OF DECEASED (Type or print) David First Donald Bryson Male 4. DATE OF DEATH Dec. 23 1967		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 29th. 1925
9. AGE (In years) 42 (Birthdays) yrs		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Funeral Director		10b. KIND OF BUSINESS OR INDUSTRY Funeral	
11. BIRTHPLACE (State or foreign country) Rock Springs Wyoming.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Emery Bryson		14. MOTHER'S MAIDEN NAME Bonnie Hampton	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) yes WW II		16. SOCIAL SECURITY NO. 523-24-2063	
17. INFORMANT Sally Bryson (Wife)		Address 1417 Jeffers, Rd.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH CAUSED BY IMMEDIATE CAUSE (a) <u>Bullet wound of head (suicide)</u> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last		INTERVAL BETWEEN ONSET AND DEATH 1 hr (est)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 8) <u>Deceased shot self in head with 22 revolver</u>	
20c. TIME OF INJURY Month, Day, Year 4 pm (AG) Dec 23 1967	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home farm factory street, office, bldg, etc) <u>Sylvan Lewis &amp; Son Funeral Home, Garrison, Baltimore</u>	20f. (City or town) (County) (State) <u>Baltimore</u>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , inspection <input checked="" type="checkbox"/> , inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>D. D. Caples</u> M.D. EXAMINER'S NAME (Type) D. D. CAPLES		22. DATE SIGNED 12-24-67	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF Dec. 26th. 1967	23c. NAME OF CEMETERY OR CREMATORY East View Cemetery	23d. LOCATION (City or Town) (County) (State) Newton, North Carolina.
24. FUNERAL DIRECTOR Sylvan S. Lewis & Son Memorial Chapel		25a. REC'D BY REGISTRAR DATE DEC 27 1967	
25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (6)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
16457											
16449											
1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institut on Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FORT HOWARD</b>				c. LENGTH OF STAY IN lb <b>18 DAYS</b>		c. (CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BALTIMORE</b>					
d. NAME OF HOSPITAL OR INST TUTION (If not in hospital, give street address) <b>VETERANS ADMINISTRATION HOSPITAL</b>						d. STREET ADDRESS <b>35C BYWAY SOUTH</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>ALVIN</b> Middle <b>OSCAR</b> Last <b>BUCKNER</b>						4. DATE OF DEATH Month <b>DECEMBER</b> Day <b>29</b> Year <b>19 67</b>					
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		B. DATE OF B RTH <b>10/10/95</b>		9. AGE (In years last birthday) yrs <b>72</b>		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>LABORER</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>TEXTILE</b>		11. BIRTHPLACE (County & State, or foreign country) <b>MARSHALL, N. CAROLINE</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>WILLIAM</b>						14. MOTHER'S MAIDEN NAME <b>LAURA RECLOR</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>YES WWI</b>				16. SOCIAL SECURITY NO <b>251 30 56 17</b>		17. INFORMANT Address <b>CLINICAL RECORDS, VAH, FT. HOWARD, MD.</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>BRONCHOPNEUMONIA</b> DUE TO (b) <b>ARTERIOSCLEROTIC HEART DISEASE WITH CONGESTIVE FAILURE</b> DUE TO (c) <b>UNK.</b>										INTERVAL BETWEEN ONSET AND DEATH <b>RECENT</b>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDIT ON GIVEN IN PART (a) <b>CHRONIC ADHESIVE PLEURITIS</b>										19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>DEC 11</b> , 19 <b>67</b> , to <b>DEC 29</b> , 19 <b>67</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>DEC 29</b> , 19 <b>67</b> , and that death occurred at <b>11:30 PM</b> , from causes and on the date stated above.											
22a. SIGNATURE <i>John D. Talbert</i>						M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <b>1/2/68</b>			
22c. PHYSICIAN'S NAME (Type) <b>JOHN D. TALBERT, M. D.</b>						22d. ADDRESS <b>VAH FORT HOWARD, MARYLAND</b>					
23a. BURIAL, CREMATION, REMOVAL <b>BURIAL</b>		23b. DATE THEREOF <b>1/5/68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>BALTO. NATIONAL CEMETERY</b>				23d. LOCATION (City or Town) (County) (State) <b>BALTIMORE, MARYLAND</b>			
24. FUNERAL DIRECTOR <i>Fisher</i> <b>FISHER FUNERAL HOME</b>						ADDRESS <b>1930 EASTERN AVE. BALTIMORE, MD.</b>		25a. REC'D BY REGISTRAR DATE <b>JAN 5 1968</b>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

8

27

...

27 2 2 2

10

27

11

x



# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

16458

16450

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Baltimore</u> b. CITY OR TOWN (If outside of corporate limits, write RURAL and give nearest town) <u>Randallstown</u> c. LENGTH OF STAY IN TB <u>1 day</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Balto. Co. General</u>		<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>md.</u> b. COUNTY _____ c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> d. STREET ADDRESS <u>4824 Palmer Ave</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) First Middle Last <u>Samuel P. Buell</u>		<b>4. DATE OF DEATH</b> Month Day Year <u>Dec. 17 1967</u>	
<b>5. SEX</b> <u>Male</u>		<b>6. COLOR OR RACE</b> <u>W</u>	
<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>6-10-87</u>	
<b>9. AGE</b> (In years last birthday) <u>80</u> yrs		<b>10. IF UNDER 1 YEAR</b> Months Days Hours Min.	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Retired Salesman</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Milk Company</u>	
<b>11. BIRTHPLACE</b> County & State, or foreign country <u>Maryland</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>USA</u>	
<b>13. FATHER'S NAME</b> <u>John Buell</u>		<b>14. MOTHER'S MAIDEN NAME</b> <u>Martha Wisner</u>	
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		<b>16. SOCIAL SECURITY NO.</b> <u>215-10-2611</u>	
<b>17. INFORMANT</b> <u>Mrs. Nellie Brewer</u>		<b>18. INTERVAL BETWEEN ONSET AND DEATH</b> (Same)	
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> (b) <u>Arteriosclerosis</u> (c) <u>Acute Pulmonary Edema 20th pos. Pulm. Embolus</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH</b> (If either notify medical examiner) <b>20b. DESCRIBE HOW INJURY OCCURRED</b> (Enter nature of injury in Part I or Part II of item 18) _____			
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. p.m. <u>19</u>			
<b>20d. INJURY OCCURRED</b> While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			
<b>20e. PLACE OF INJURY</b> Home, farm, factory, street, office bldg., etc.) _____			
<b>20f. (City or town)</b> _____ <b>(County)</b> _____ <b>(State)</b> _____			
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>12/17</u> <b>to</b> <u>12/17</u> , <b>that (I) (we) last saw the deceased alive on</b> <u>12/17</u> , <b>and that death occurred at</b> <u>12/17</u> <b>from the causes and on the date stated above.</b>			
<b>22a. SIGNATURE</b> <u>Acting</u>		<b>22b. DATE SIGNED</b> <u>12/17/67</u>	
<b>22c. PHYSICIAN'S NAME</b> (Type) _____		<b>22d. ADDRESS</b> <u>Balto. County General Hospital</u>	
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Burial</u>		<b>23b. DATE THEREOF</b> <u>12/20/67</u>	
<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Gardens of Faith Cemetery</u>		<b>23d. LOCATION</b> (City, town or county) <u>Baltimore, Md.</u> (State) _____	
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Leonard J. Ruck, Inc. Balto. Md. 21214</u>		<b>25a. REC'D BY REGISTRAR</b> <u>DEC 18 1967</u> <b>25b. REGISTRAR'S SIGNATURE</b> <u>J. C. Jones</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. Page 2 may be retained by the funeral director. Page 3 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2, and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

16451

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

16451

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE COUNTY</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>TOWSON</b> c. LENGTH OF STAY IN 1b		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>—</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>GREATER BALTIMORE MEDICAL CENTER</b>		e. STREET ADDRESS <b>2922 HUDSON STREET</b>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>ANDREW LEONARD BUETTNER</b>		4. DATE OF DEATH Month Day Year <b>DEC 16 1967</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>CAU</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>12/23/06</b>
9. AGE (In years last birthday) <b>60</b> yrs.		10. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>BAKER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>BAKERY</b>	
11. BIRTH PLACE (County & State, or foreign country) <b>BALTIMORE, MD.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>JOHN BUETTNER</b>		14. MOTHER'S MAIDEN NAME <b>K. DUENMERICK</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b> (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <b>212-22-3678</b>	
17. INFORMANT <b>CHART ADMISSION SHEET.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cancer of Esophagus</b> DUE TO (b) <b>Pneumonia</b> DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			
INTERVAL BETWEEN ONSET AND DEATH <b>11/30/67</b> <b>12/16/67</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>11/30, 1967</b> , to <b>12/16, 1967</b> , that (I) (we) last saw the deceased alive on <b>12/16/1967</b> , and that death occurred at <b>10:20 AM</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>A. Pirnia, M.D.</b>		22b. DATE SIGNED <b>12/16/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>DR. PIRNIA M.D.</b>		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>12-19-67</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>St. Stanislaus Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Baltimore, Md.</b>	
23e. FUNERAL DIRECTOR <b>Nicholas T. Matthews</b>		23f. ADDRESS <b>3021 Eastern Ave.</b>	
25a. REC'D BY REGISTRAR <b>DEC 21 1967</b>		25b. REGISTRAR'S SIGNATURE <b>Nicholas T. Matthews</b>	

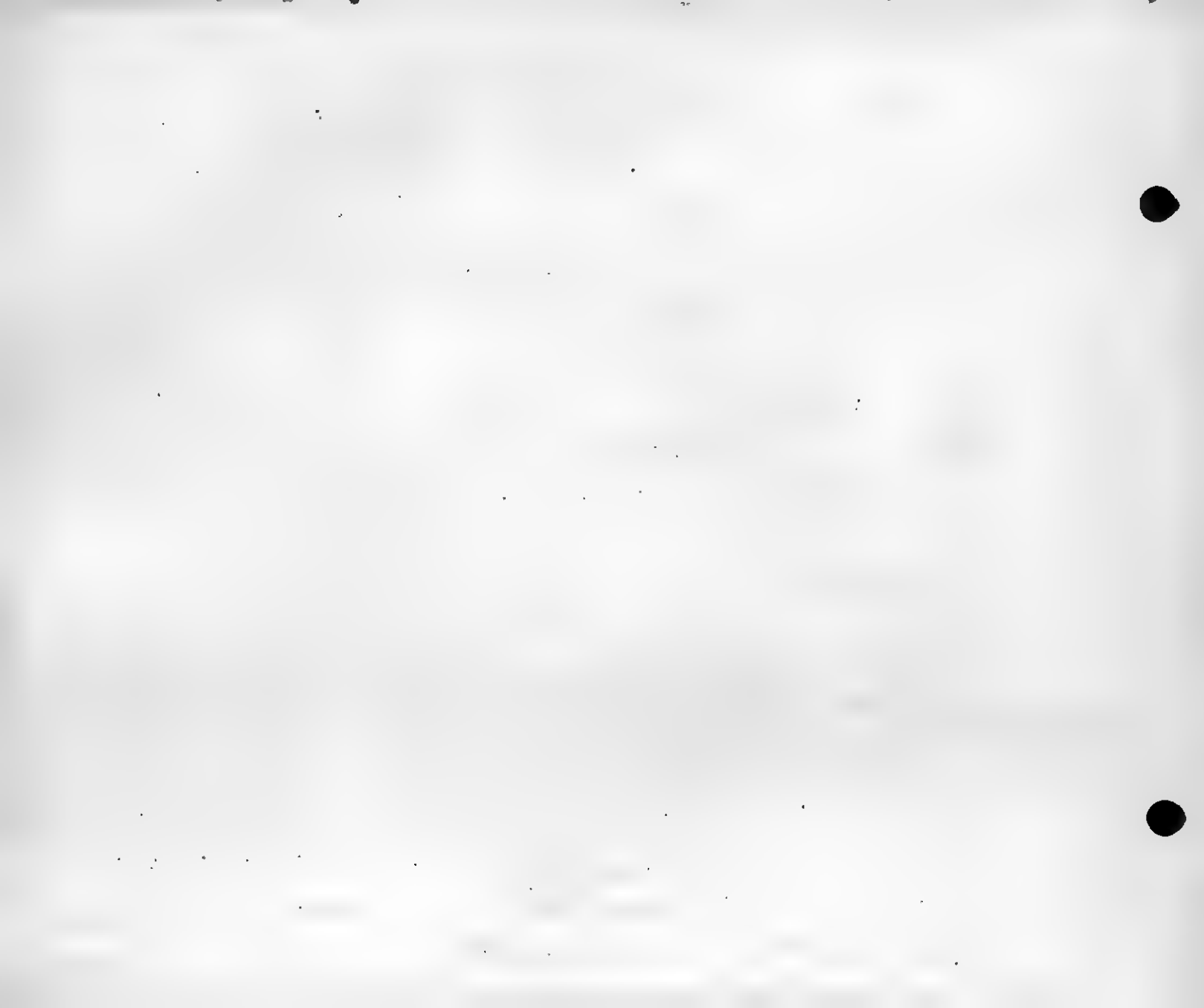


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY <u>Baltimore - County</u> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u>						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore, Maryland</u>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Greater Balto. Medical Center</u>						d. STREET ADDRESS <u>1600 East Coldspring Lane</u>					
3. NAME OF DECEASED (Type or print) First <u>Ida</u> Middle <u>Mae</u> Last <u>Burdette</u>						4. DATE OF DEATH Month <u>12</u> Day <u>12</u> Year <u>1967</u>					
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Cau</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>7-16-05</u>		9. AGE (In years last birthday) <u>62</u> yrs.		10. IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Akron, Ohio</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John Westfall</u>						14. MOTHER'S MAIDEN NAME <u>Rachel (Westfall) unknown</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>unknown</u>				16. SOCIAL SECURITY NO. <u>unknown</u>		17. INFORMANT Address <u>  </u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cancer of Hypopharynx</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>  </u> DUE TO (c) <u>  </u>										INTERVAL BETWEEN ONSET AND DEATH <u>1 1/2 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>  </u> p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		20g. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>12-12-67</u> , 19 <u>67</u> to <u>12-12-67</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>12-12-67</u> , 19 <u>67</u> , and that death occurred at <u>5:03 PM</u> from the causes and on the date stated above.											
22a. SIGNATURE <u>P B Briscoe Jr</u>										22b. DATE SIGNED <u>12-12-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>P B BRISCOE Jr.</u>						22d. ADDRESS <u>Greater Balto. Med. Center</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>CREMATION</u>				23b. DATE THEREOF <u>12-16-67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>GREEN MOUNT</u>		23d. LOCATION (City, town or county) (State) <u>BALTIMORE MD</u>			
24. FUNERAL DIRECTOR <u>ROBERT C. ALTENBURG</u>						25a. REC'D BY REGISTRAR <u>6009 HARFORD RD</u>		25b. REGISTRAR'S SIGNATURE <u>John Charles Judge</u>			
FUNERAL HOME, INC						DATE <u>DEC 20 1967</u>					



DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

Item 18 File # 33961/2/68ph  
 16453 Item 19 File # 33961/2/68ph  
 16453

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Reisterstown</b> c. LENGTH OF STAY IN 1b <b>month</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Rt. 3 Box 48 Hanover Rd.</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cockeysville</b> d. STREET ADDRESS <b>4 Shawan Rd.</b>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Charles C. Burke</b>		4. DATE OF DEATH Month Day Year <b>December 8, 1967</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug, 8, 1888 1899</b>
9. AGE (In years last birthday) <b>68</b> yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Carpenter</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>	
13. FATHER'S NAME <b>Conrad A. Conrad H. Burk</b>		14. MOTHER'S MAIDEN NAME <b>Mary E. Guyton</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>216-07-4349</b>	
17. INFORMANT <b>Mrs. Mary B. Turnbaugh</b>		Address <b>Rt. 3 Box 48 Hanover Rd.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchogenic Carcinoma - right lung</b> (b) <b>5 months</b> (c) <b>INTERVAL BETWEEN ONSET AND DEATH</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>July 1967</b> to <b>December 8, 1967</b> , that (I) (we) last saw the deceased alive on <b>December 8, 1967</b> , and that death occurred at <b>3:30 PM</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>Clarence E. McWilliams</b>		22b. DATE SIGNED <b>12-8-67</b>	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS <b>11904 Reisterstown Rd Reisterstown Md 21136</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>12/11/67</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>St. Johns Lutheran Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Sweet Air, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Wm. Cook-Brooks</b>		25a. REC'D BY REGISTRAR (Type) <b>DEC 13 1967</b>	
Towson 1050 York Rd. 21204		DATE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.









1  
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

16463  
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH  
13451

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b> c. LENGTH OF STAY IN 1b <b>MARYLAND</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>1207 Black Friars Rd 21228</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Balt</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b> d. STREET ADDRESS <b>1207 Black Friars Rd 21228</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Ida Velinda Butz</b>		4. DATE OF DEATH Month Day Year <b>12 3 1967</b>	
5. SEX <b>Female</b>		6. COLOR OR RACE <b>Cau</b>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>2/2/81</b>	
9. AGE (In years last birthday) <b>86</b> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Jesse N. Hill</b>		14. MOTHER'S MAIDEN NAME <b>Elizabeth Hart</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>218-07-6758D</b>	
17. INFORMANT <b>Mrs Vera Moore</b>		Address <b>44 Dunkirk Rd. Balt. Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>4201</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Myocardial Infarction</b> DUE TO (c) <b>A.P.O.D. - Myocardial Infarction</b>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>9/1</b> , 19 <b>67</b> , to <b>12/3</b> , 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>12/3</b> , 19 <b>67</b> , and that death occurred at <b>7 AM</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>Ida Velinda Butz</b>		22b. DATE SIGNED <b>12/4/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>Ida Velinda Butz</b>		22d. ADDRESS <b>5500 Edmonson Ave. Balt. Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>12/6/67</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Louisa Park</b>		23d. LOCATION (City, town or county) (State) <b>Baltimore, Md.</b>	
24. FUNERAL DIRECTOR <b>Wm. Cook-Brooks West, Inc</b>		25a. REC'D BY REGISTRAR <b>DEC 7 1967</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles J. Jones</b>			



## CERTIFICATE OF DEATH

16464

6456

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE <u>Maryland</u> b. COUNTY <u>Pikeville</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Darvson</u>		c. LENGTH OF STAY IN 1b <u>8203 Pumpkin Seed Ct</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospita, give street address) <u>Foxleigh Nursing Home</u>		d. STREET ADDRESS <u>8203 Pumpkin Seed Ct</u>	
3. NAME OF DECEASED (Type or print) First <u>Maurice</u> Middle <u>U.</u> Last <u>Cohn</u>		4. DATE OF DEATH Month <u>December</u> Day <u>8</u> Year <u>1967</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 9, 1871</u>
9. AGE (In years last birthday) <u>96</u> yrs		10. IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of work days, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Merchant</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Baltimore, Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Bernard Cohn</u>		14. MOTHER'S MAIDEN NAME <u>Hannah ?</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO <u>Seed Ct</u>	
17. INFORMANT <u>Charles Cohn Jr - 8203 Pumpkin</u>		Address <u>Seed Ct</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia, lobular</u> + <u>YUX</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u>	
PART II: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Benign Prostatic Hypertrophy</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter notes of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>0</u> m. <u>19</u> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Feb</u> , 19 <u>67</u> to <u>Dec 8</u> , 19 <u>67</u> , that (I) (we) lost saw the deceased alive on <u>Dec 6</u> , 19 <u>67</u> , and that death occurred at <u>6:30</u> M., from causes and on the date stated above.			
22a. SIGNATURE <u>Alan Bernstein</u>		22b. DATE SIGNED <u>12/9/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>ALAN BERNSTEIN</u>		22d. ADDRESS <u>819 Park Ave Balt 21201</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Dec 10/67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Baile Hebrew</u>		23d. LOCATION (City or town) (County) (State) <u>Baile, Md</u>	
24. FUNERAL DIRECTOR <u>Sol Levinson &amp; Son Inc - 6010 Reist. Rd</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		DATE <u>DEC 12 1967</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
16465						CERTIFICATE OF DEATH			16457		
1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Queen Anne</b>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Owings Mills</b>				c. LENGTH OF STAY IN 1b <b>17 yrs.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Millington</b>					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Rosewood State Hospital</b>						d. STREET ADDRESS <b>R.F.D.</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Evelyn</b> Middle <b>-</b> Last <b>CANNON</b>						4. DATE OF DEATH Month <b>12</b> Day <b>20</b> Year <b>1967</b>					
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>3-19-45</b>		9. AGE (In years last birthday) <b>22</b> yrs		10. IF UNDER 1 YEAR Months <b>22</b> Days <b>20</b> Hours <b>19</b> Min <b>67</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Dependent</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>none</b>		11. BIRTHPLACE (County & State or foreign country) <b>Baltimore City, M.D.</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Thomas Cannon</b>						14. MOTHER'S MAIDEN NAME <b>Dorothy Hamilton</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>				16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT Address <b>Rosewood Records, Owings Mills, Maryland</b>					
18. CAUSE OF DEATH (Enter any one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Asphyxia/deficiency</b> <b>Asphyxia</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause } (b) <b>Aspiration of food</b> <b>Aspiration of gastric contents</b> DUE TO (c) <b>Mental Retardation</b>										INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Institutionalization, 17 years, Mental Retardation</b>										19. WAS A TOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (1) (this hospital) attended the deceased from <b>2/21</b> , 19 <b>50</b> , to <b>12/20</b> , 1967, that (2) (we) last saw the deceased alive on <b>12/20</b> , 1967, and that death occurred at <b>10:10 a.m.</b> causes and on the date stated above.											
22a. SIGNATURE <b>Richard A. Jones</b> M.D.						ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22b. DATE SIGNED <b>12/21/67</b>			
22c. PHYSICIAN'S NAME (Type) <b>Richard A. Jones, M.D.</b>						22d. ADDRESS <b>Rosewood St. Hosp., Owings Mills, Md.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				23b. DATE THEREOF <b>12-24-67</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Greensboro</b>		23d. LOCATION (City or Town) (County) (State) <b>Greensboro, Md.</b>			
24. FUNERAL DIRECTOR <b>John E. Benning, Greensboro, Md.</b>						25a. REC'D BY REGISTRAR <b>DEC 27 1967</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>			





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

16465

16458

1 PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FORT HOWARD</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BALTIMORE</b>	
c. LENGTH OF STAY IN 1b <b>113 DAYS</b>		d. STREET ADDRESS <b>3145 CLIFTMONT AVENUE</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>VETERANS ADMINISTRATION HOSPITAL</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First Middle Last <b>JOB (or JOSEPH) CARLO</b>		4. DATE OF DEATH Month Day Year <b>DECEMBER 19 19 67</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>7 27 92</b>
9. AGE (In years lost birthday) yrs <b>75</b>		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>BROOM MAKER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Md. Blind Shop</b>	
11 BIRTHPLACE (County & State, or foreign country) <b>Italy</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>CARMELLO CARLO</b>		14. MOTHER'S MAIDEN NAME <b>ROSARIA VICARI</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>YES WW I</b>		16. SOCIAL SECURITY NO. <b>212 32 3307</b>	
17. INFORMANT <b>CLINICAL RECORDS VA HOSP FT HOWARD, MD</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>PNEUMONIA, BILATERAL, ASPIRATION, UNDETERMINED ORGANISM-DAYS</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>—</b> DUE TO (c) <b>CHRONIC BRAIN SYNDROME, CEREBRAL ARTERIOSCLEROSIS</b> UNKNOWN		INTERVAL BETWEEN ONSET AND DEATH <b>DAYS</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)	20f. (City or town) (County) (State)
21. I certify that <b>he</b> (this hospital), attended the deceased from <b>8/28/67</b> , 19__, to <b>12/19/67</b> , 19__, that <b>he</b> (we) last saw the deceased alive on <b>12/19/67</b> , 19__, and that death occurred on <b>8:00AM</b> , from causes on and on the date stated above.			
22a. SIGNATURE <i>Neilon Neilson</i>		22b. DATE SIGNED <b>12/19/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>NEILON NEILSON, M. D.</b>		22d. ADDRESS <b>VA HOSPITAL FORT HOWARD, MARYLAND</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>12/22/67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Balto. Nat. Cem.</b>	23d. LOCATION (City or Town) (County) (State) <b>Baltimore, Md.</b>
24. FUNERAL DIRECTOR <b>SCHIMUNEKS FUNERAL HOME, BRBHMS LANE BALTO MD</b>		25a. REC'D BY REGISTRAR <b>DEC 21 1967</b>	
ADDRESS		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

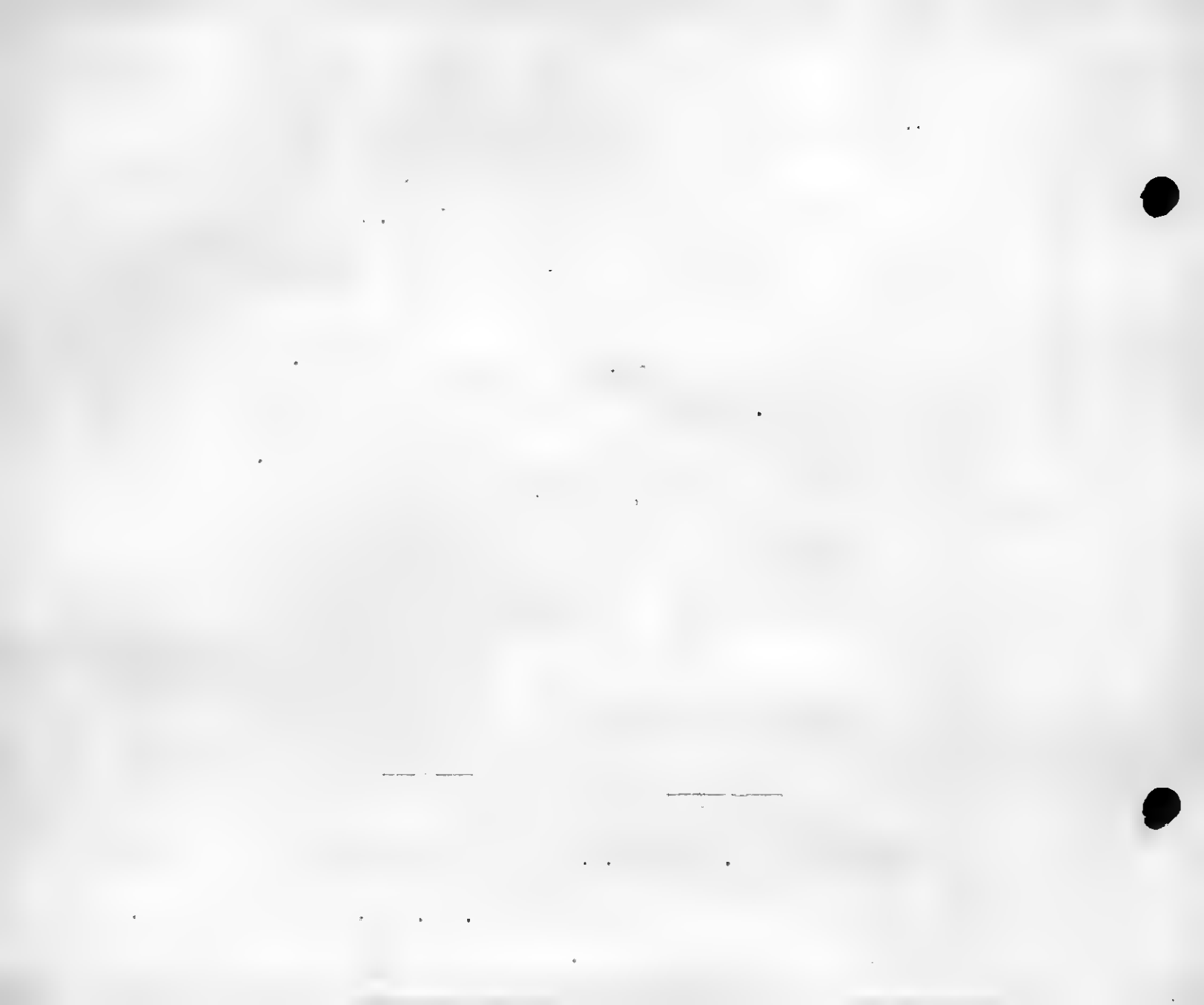
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

16467

16459

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Towson</b>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>		2	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Briarcliff Apartments</b>				d. STREET ADDRESS <b>1718 W. Lombard Street</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) F. First M. Middle L. Last <b>CHESTER LLOYD CARROLL</b>				4. DATE OF DEATH Month Day Year <b>December 19, 1967</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3/4/26</b>	9. AGE (in years last birthday) <b>41</b> yrs	10. UNDER 1 YEAR Months Days		11. UNDER 24 HRS Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Painter</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Self-Employed</b>		11. BIRTHPLACE (State or foreign country) <b>Staunton, Va.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Cecil L. Carroll</b>				14. MOTHER'S MAIDEN NAME <b>Julia Hollinger</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>yes WW II</b>		16. SOCIAL SECURITY NO <b>WW II</b>		17. INFORMANT <b>C. L. Carroll</b> Address <b>1718 W. Lombard St.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Arteriosclerotic Cardiovascular Disease</b> 4221 DUE TO (b) _____ (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (a) _____ (b) _____ (c) _____						INTERVAL BETWEEN ONSET AND DEATH	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. _____ 19__		20d. NATURE OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, room, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from <u>Natural causes</u> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>Werner U. Spitz, M.D.</b>				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>Werner U. Spitz, M.D.</b>				22. DATE SIGNED <b>12/19/67</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY <b>Alleghany Mem. Pk. Cem.</b>		23d. LOCATION (City or Town) (County) (State) <b>Alleghany, Va.</b>	
24. FUNERAL DIRECTOR <b>Witke R. D. - 4101 Edmondson Ave.</b>				25a. REC'D BY REGISTRAR DATE <b>DEC 21 1967</b>		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>	



16468

CERTIFICATE OF DEATH

16460

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>City, Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. LENGTH OF STAY in 1b <b>54yr11mth23dys</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore, Maryland</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Spring Grove State Hospital</b>		d. STREET ADDRESS <b>Unknown</b>	
3 NAME OF DECEASED (Type or print) First <b>William</b> Middle <b>Carroll</b> Last <b>Carroll</b>		4. DATE OF DEATH Month <b>Dec.</b> Day <b>23</b> Year <b>1967</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1899</b>
9. AGE (In years last birthday) yrs <b>70</b>		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11 BIRTHPLACE (County & State, or foreign country) <b>Baltimore City, Md.</b>		12 CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13 FATHER'S NAME <b>Henry K. Carroll</b>		14. MOTHER'S MAIDEN NAME <b>Mary Sullivan</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Records: Spring Grove State Hospital</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Pneumonia, bronchial, organism undeter-</b> DUE TO <b>provisional diagnosis.</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Carcinoma of the lung, type undetermined,</b> DUE TO <b>6 months</b> (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Bronchial(rt.)-esophageal fistula.</b>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>Nov. 28, 1962</b> to <b>Dec. 23, 1967</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>Dec. 23, 1967</b> , and that death occurred at <b>8:25M</b> , from causes and on the date stated above.			
22a. SIGNATURE <i>Anthony J. Young</i>		22b. DATE SIGNED <b>12-23-67</b>	
22c. PHYSICIAN'S NAME (Type) <b>Anthony J. Young, M.D.</b>		22d. ADDRESS <b>Spring Grove State Hospital Baltimore, Maryland 21228</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>12/27/1967</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Mount Carmel Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Baltimore, Maryland</b>	
24. FUNERAL DIRECTOR <b>John A. Moran Inc. 3000 E. Baltimore Street</b>		25a. REC'D BY REGISTRAR DATE <b>DEC 29 1967</b>	
25b. REGISTRAR'S SIGNATURE <i>h</i>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

1646

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

16461

1 PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. LENGTH OF STAY IN 1b <b>45yr11mth16dys</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>SPRING GROVE STATE HOSPITAL</b>		d. STREET ADDRESS <b>unknown</b>	
3 NAME OF DECEASED (Type or print) <b>Ira C. Carson</b>		4 DATE OF DEATH Month <b>December</b> Day <b>18</b> Year <b>1967</b>	
5 SEX <b>male</b>	6 COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 23, 1884</b>
9 AGE (In years last birthday) <b>83 yrs</b>		IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11 BIRTHPLACE (County & State, or foreign country) <b>Illinois</b>		12 CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>Henry Carson</b>		14 MOTHER'S MAIDEN NAME <b>Jennie Herring</b>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16 SOCIAL SECURITY NO <b>219-54-3064</b>	
17 INFORMANT <b>Records: SPRING GROVE STATE HOSPITAL</b>		Address	
18 CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c)) <b>Myocardial Infarction with supraventricular</b>		INTERVAL BETWEEN ONSET AND DEATH <b>10 min.</b>	
IMMEDIATE CAUSE (a) <b>4 - - - - -</b>		DUE TO <b>lar tachycardia</b>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		(b) <b>Arteriosclerotic Cardiovascular Ht. Dis.</b>	
		(c)	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Descent</b>			
<b>Suprapubic Cystolithotomy &amp; Prostatectomy, 12/15/67, convalescent</b>			
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work	
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>Jan. 2, 1922</b> to <b>Dec. 18, 1967</b> , that (I) <b>we</b> last saw the deceased alive on <b>Dec. 18, 1967</b> , and that death occurred at <b>4:30 P.</b> M, from causes and on the date stated above			
22a SIGNATURE <b>Anthony J. Young, M.D.</b>		22b. DATE SIGNED <b>12-18-67</b>	
22c PHYSICIAN'S NAME (Type)		22d ADDRESS <b>SPRING GROVE STATE HOSPITAL</b> <b>Baltimore, Maryland 21228</b>	
23a BURIAL, CREMATION, REMOVAL (Specify)		23b DATE THEREOF <b>12-20-67</b>	
23c NAME OF CEMETERY OR CREMATORY <b>New Cathedral</b>		23d LOCATION (City or town) (County) (State) <b>Old Frederick Road, Baltimore</b>	
24 FUNERAL DIRECTOR <b>Krause Funeral Home 1216 Schaefer St</b>		25a REC'D BY REGISTRAR <b>DATE DEC 27 1967</b>	
25b REGISTRAR'S SIGNATURE <b>[Signature]</b>			



.

..

— —

.

.

.

.

.

.

..

.





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

16470

16463

1 PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b>		c. LENGTH OF STAY IN 1b <b>83 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Veterans Administration Hospital</b>				d STREET ADDRESS <b>1200 N. Rolling Road</b>		e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) <b>ELMER</b>		First Middle Last <b>CHANEY</b>		4 DATE OF DEATH Month <b>December</b> Day <b>27</b> Year <b>1967</b>			
5 SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>7/18/94</b>		9 AGE (in years 1 birthday) yrs. <b>73</b>	F UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Cab Driver</b>		10b. KIND OF BUSINESS OR INDUSTRY		11 BIRTHPLACE (County & State, or foreign country) <b>Baltimore, Maryland</b>		12 CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Clarence Chaney</b>				14. MOTHER'S MAIDEN NAME <b>Irene Williams</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>Yes WW-1</b>		16 SOCIAL SECURITY NO. <b>216 09 25 14</b>		17 INFORMANT Address <b>Clinical Recds, VA Hospital, Ft Howard, Md.</b>			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>BRONCHO-PNEUMONIA</b> 4-200 DUE TO (b) <b>ARTERIOSCLEROTIC HEART DISEASE WITH CONGESTIVE</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO <b>HEART FAILURE</b> (c)						INTERVAL BETWEEN ONSET AND DEATH <b>Recent</b>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>DIABETES MELLITUS (CLINICAL) SURGICAL ABSENCE LEFT LEG</b>						19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work		20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>Oct. 5</b> , 19 <b>67</b> , to <b>Dec. 27</b> , 19 <b>67</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>12/27/67</b> , 19 <b>67</b> , and that death occurred at <b>8:20 M</b> , from causes and on the date stated above.							
22a SIGNATURE <b>Madhav D. Barhanpurkar</b> M.D.				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b DATE SIGNED <b>12/27/67</b>	
22c PHYSICIAN'S NAME (Type) <b>MADHAV D. BARHANPURKAR, M.D.</b>				22d ADDRESS <b>VA Hospital, Fort Howard, Md.</b>			
23a BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b DATE THEREOF <b>Jan. 2, 1968</b>		23c NAME OF CEMETERY OR CREMATORY <b>Baltimore National</b>		23d LOCATION (City or Town) (County) (State) <b>Baltimore, Md.</b>	
24. FUNERAL DIRECTOR <b>Henry Sander &amp; Sons Inc.</b> <b>SANDERS FUNERAL HOME</b>				ADDRESS <b>North &amp; Broadway</b> <b>Balto, Md.</b>		25a REC'D BY REGISTRAR DATE <b>JAN 2 1968</b>	
				25b REGISTRAR'S SIGNATURE <i>[Signature]</i>			



CERTIFICATE OF DEATH

16471

16464

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Parkton</u>		c. LENGTH OF STAY IN 1b <u>Life</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Bush Land Road</u>		d. STREET ADDRESS <u>Bush Land Road</u>	
3 NAME OF DECEASED (Type or print) <u>John Clarence Chilcoat</u>		4. DATE OF DEATH Month <u>Dec.</u> Day <u>17</u> Year <u>1967</u>	
5 SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 21 1879</u>
9 AGE (In years last birthday) <u>88</u> yrs		10. IF UNDER 1 YEAR Months <u>17</u> Days <u>19</u> Hours <u>67</u> Min	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Agriculture</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Baltimore County Md</u>		12 CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>George R. Chilcoat</u>		14. MOTHER'S MAIDEN NAME <u>Laura Guyton</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO <u>215-54-1437</u>	
17 INFORMANT <u>Mrs Gladys Marshall</u> Address <u>Parkton Md</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arterio-sclerotic Cardio Vascular disease</u> 4221 DUE TO (b) <u>Chronic Myocarditis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <u>?</u>			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>?</u>			
19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item B) <u>?</u>	
20c TIME OF INJURY Month, Day, Year Hour <u>0</u> m. <u>19</u> p.m.	20d INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work	20e PLACE OF INJURY (Home, farm, factory, street, office bldg, etc) <u>?</u>	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>Jan 6</u> , 19 <u>55</u> , to <u>Dec 17</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>Dec 10</u> 19 <u>67</u> , and that death occurred at <u>3:30 PM</u> , from causes and on the date stated above			
22a SIGNATURE <u>Joseph E. Bush MD</u>		22b. DATE SIGNED <u>12-17-67</u>	
22c PHYSICIAN NAME (Type) <u>Joseph E. Bush MD</u>		22d ADDRESS <u>NAMPTON Maryland</u>	
23a BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>12/20/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Carmel Cem.</u>	23d. LOCATION (City or Town) (County) (State) <u>Parkton, Balto., Md.</u>
24. FUNERAL DIRECTOR <u>J. Jacob Hartenstein, New Freedom, Pa.</u>		25a REC'D BY REGISTRAR <u>Charles Judge</u> 25b REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



## 16465

## MEDICAL CERTIFICATION

NR A15 (4)  
EDM 1/65



### CERTIFICATE OF DEATH

10466

S P.

1. NAME OF DECEASED (Type or Print)		MARGARET S. CLARK		2. DATE AND HOUR OF DEATH December 19, 1967.		10-10-67 8 P.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND BALTIMORE COUNTY (If not in hospital or institution, give street address or location) 4417 Glenmore Avenue				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY BALTIMORE C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore 21206 D. STREET ADDRESS (If rural, give location) 4417 Glenmore Avenue			
5. SEX Female	6. RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH July 13, 1894.	9. AGE (In years last birthday) 73	10. Under 1 Yr. Months Days	11. Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John N. Suwalski				14. MOTHER'S MAIDEN NAME Margaret Kraning			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Mr. Augustus W. Clark		ADDRESS (Same)	
18. I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Hypertensive C-V disease with renal failure Pulmonary fibrosis Emphysema ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) slowing the UNDERLYING CONDITION last. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Recurrent colitis & malnutrition I certify that (1) (this hospital) attended the deceased from Dec. 19, 1967 to Dec. 19, 1967 and that (1) (my) lost saw the deceased alive on Dec. 19, 1967 and that in (my) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did not) view the body after death.				INTERVAL BETWEEN ONSET AND DEATH 15 yrs 20 yrs			
23A. SIGNATURE H. V. Harbold				23B. DATE SIGNED Dec. 20, 1967			
23C. PHYSICIAN'S NAME (Type) H. V. HARBOLD				23D. ADDRESS 4706 Harford Road Baltimore, Md.			
24A. BURIAL, CREMATION, REMOVAL (Specify) Burial		24B. DATE 12/23/67.		24C. NAME OF CEMETERY or CREMATORY Moreland Memorial Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT. DEC 22 1967				25B. NAME OF REGISTRAR Charles J. ...		25C. FUNERAL DIRECTOR Leonard J. ...	

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

VR A15 (4)  
25M 1/6





16474

CERTIFICATE OF DEATH

10467

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Towson</b> c. LENGTH OF STAY IN 1b <b>Hours</b>		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore 21224</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>ST. JOSEPH HOSPITAL</b>		d. STREET ADDRESS <b>1144 Steelton Ave.</b>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Norman Edward CLARK</b>		4. DATE OF DEATH Month Day Year <b>December 18, 1967</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>12/17/67</b>
9. AGE (In years last birthday) <b>6</b>		10. IF UNDER 1 YEAR Months Days Hours Mins <b>35</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Baltimore, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>David H. Clark</b>		14. MOTHER'S MAIDEN NAME <b>Cynthia L. Clark</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT (Father) <b>Mr. David H. Clark, 1144 Steelton Ave.</b>		18. ADDRESS <b>Balto. Md. 21224</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH CAUSED BY: IMMEDIATE CAUSE (a) <b>Respiratory distress syndrome</b> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (M) (this hospital) attended the deceased from <b>12/17/</b> , 19 <b>67</b> , to <b>12/18/</b> , 19 <b>67</b> that (X) (we) last saw the deceased alive on <b>12/18/</b> , 19 <b>67</b> , and that death occurred at <b>5:45 M.</b> from causes and on the date stated above.			
22a. SIGNATURE <b>William</b>		22b. DATE SIGNED <b>12/18/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>Ines Cilliani, M.D.</b>		22d. ADDRESS <b>7620 York Rd., Towson, Md. 21204</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>12/20/67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National Cem.</b>	23d. LOCATION (City or Town) (County) (State) <b>Baltimore, Md.</b>
24. FUNERAL DIRECTOR <b>John J. Duda, 7922 Wise Ave. Dundalk, Md.</b>		25. REGISTRY BY REGISTRAR DATE <b>DEC 22 1967</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If only delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Pages 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

16475

16468

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sparrow's Point</b>		c. LENGTH OF STAY IN 1b <b>Baltimore</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>PLANT DISPENSARY</b>		d. STREET ADDRESS <b>1406 N. Fulton Ave.</b>	
3. NAME OF DECEASED (Type or print) <b>THOMAS</b> First Middle Last		4. DATE OF DEATH <b>December 27 1967</b> Month Day Year	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negroid</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>8-15-10</b> 9. AGE (In years and birthday) <b>57</b> yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Labor</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Steel</b>	11. BIRTHPLACE (State or foreign country) <b>Danville, Virginia</b>
13. FATHER'S NAME <b>UNK.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>228-16-6793</b>		16. SOCIAL SECURITY NO. <b>228-16-6793</b>	
17. INFORMANT <b>Mrs. Lillie Mae Clark</b>		Address <b>2414 Callow</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART DEATH WAS CAUSED BY: <b>4201</b> IMMEDIATE CAUSE (a) <b>acute coronary occlusion</b> DUE TO <b>HCUV</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) (c) INTERVAL BETWEEN ONSET AND DEATH			
PART I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>2</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <b>2</b>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. _____ 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>factory</b>	20f. (City or town) (County) (State) <b>Baltimore</b>
21. I certify that I took charge of the remains described above. I held an Autopsy <input type="checkbox"/> . I inspect an <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Thos C. Patterson</b> EXAMINER'S NAME (Type) <b>THEO. C. PATTERSON</b>		22. DATE SIGNED <b>12/27/67</b> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>1-2-67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Balto. Nat'l Cem.</b>	23d. LOCATION (City or Town) (County) (State) <b>Baltimore, Maryland</b>
24. FUNERAL DIRECTOR <b>MORTON &amp; DYETT F.H. 1701 Laurens St.</b>		25a. REC'D BY REGISTRAR <b>ME 628 1967</b>	25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>



# MARYLAND STATE DEPARTMENT OF HEALTH

## DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

### CERTIFICATE OF DEATH

1647

16469

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Baltimore</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>RANDALLSTOWN</u> c. LENGTH OF STAY IN 1b  d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Baltimore County General Hospital</u>		<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <del>XXXXXX</del> <u>MARYLAND</u> b. COUNTY  c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>BALTIMORE</u> d. STREET ADDRESS <u>8023B Woodgate Ct., APT B</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) <u>Cohen, Sol</u> First Middle Last <u>COHEN</u> <del>COHEN</del>		<b>4. DATE OF DEATH</b> Month Day Year <u>December 26 1967</u>	
<b>5. SEX</b> <u>male</u>	<b>6. COLOR OR RACE</b> <u>white</u>	<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <u>4-9-1905</u>
<b>9a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>PROPRIETOR</u>	<b>9b. KIND OF BUSINESS OR INDUSTRY</b> <u>RESTAURANT</u>	<b>9c. BIRTHPLACE</b> (County & State, or foreign country) <u>RUSSIA</u>	<b>9d. AGE</b> (In years last birthday) <u>62 yrs</u> IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours M.n.
<b>10a. FATHER'S NAME</b> <u>MAX COHEN</u>		<b>10b. MOTHER'S MAIDEN NAME</b> <u>BESSIE ?</u>	
<b>11. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>		<b>12. SOCIAL SECURITY NO</b> <u>215-32-3634</u>	
<b>13. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Gen. ASCVD with multiple Cerebrovascular Accidents</u> (b) <u>4021</u> (c) <u>4021</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		<b>14. INTERVAL BETWEEN ONSET AND DEATH</b>  <b>15. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a), (b), and (c)			
<b>16a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (If either, notify medical examiner) <input type="checkbox"/>		<b>16b. DESCRIBE HOW INJURY OCCURRED</b> (Enter nature of injury in Part I or Part II of item 18)	
<b>17a. TIME OF INJURY</b> Month, Day, Year Hour a.m. p.m.  19	<b>17b. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	<b>17c. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)	<b>17d. (City or town)</b>  <b>17e. (County)</b>  <b>17f. (State)</b>
<b>18. I certify that (I) (this hospital) attended the deceased from</b> <u>12-23 1967</u> <b>to</b> <u>12-26 1967</u> <b>that (I) (we) last saw the deceased alive on</b> <u>12-26 1967</u> <b>and that death occurred at</b> <u>4:15 pm</u> <b>from the causes and on the date stated above.</b>			
<b>19a. SIGNATURE</b> <u>Dr. Morton J. Ellin</u> <b>19b. PHYSICIAN'S NAME (Type)</b> <u>DR. MORTON J. ELLIN</u>		<b>19c. ATTENDING PHYSICIAN</b> <input checked="" type="checkbox"/> <b>MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input type="checkbox"/> <b>19d. ADDRESS</b> <u>8629 LIBERTY ROAD</u>	
<b>20a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>BURIAL</u>	<b>20b. DATE THEREOF</b> <u>12-31-67</u>	<b>20c. NAME OF CEMETERY OR CREMATORY</b> <u>LUBOWITZ AGUDAS ACHIN</u>	<b>20d. LOCATION (City, town or county)</b> <u>BALTIMORE, MARYLAND</u> (State)
<b>21. FUNERAL DIRECTOR'S SIGNATURE</b> <u>SOL LEVINSON &amp; BROS. INC.</u>		<b>21a. ADDRESS</b> <u>6010 REISTERSTOWN ROAD</u>	
<b>22a. REC'D BY REGISTRAR</b>		<b>22b. REGISTRAR'S SIGNATURE</b> <u>Judge</u>	

TO HOSPITAL: After the death certificate has been signed by the attending physician and the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
1647  
16470

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> 42 1/2 Winters Avenue b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u> c. LENGTH OF STAY IN 1b <u>Life</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 42 1/2 Winters Avenue		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u> d. STREET ADDRESS 42 1/2 Winters Avenue	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Mabel M. Coleman</u>		4. DATE OF DEATH Month Day Year <u>Dec. 29 1967</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Col.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 17 1890</u>
9. AGE (In years last birthday) <u>77</u> yrs.		10. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Catonsville Maryland</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13. FATHER'S NAME <u>Timothy I. Ebb</u>		14. MOTHER'S MAIDEN NAME <u>Martha Dorsey</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. 17. INFORMANT <u>217-01-1765D Mable Fletcher 85 Wintres Avenue</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Concictive Heart Failure</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>ASCVD</u> (c) <u>ASCVD</u> (e), stating the underlying cause last. DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)		INTERVAL BETWEEN ONSET AND DEATH <u>6</u> MO. <u>20 yrs.</u>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	
20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>December 18, 1967 to December 29, 1967</u>	
20f. (City or town) (County) (State) <u>December 18, 1967 to December 29, 1967</u>		21. I certify that (I) (this hospital) attended the deceased from <u>December 18, 1967</u> to <u>December 29, 1967</u> , that (I) (we) last saw the deceased alive on <u>December 29, 1967</u> , and that death occurred at <u>8 AM</u> , from the causes and on the date stated above.	
22a. SIGNATURE <u>James E. Rowe</u> M.D.		22b. DATE SIGNED <u>12/29/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>James E. Rowe</u>		22d. ADDRESS <u>5550 Baltimore, National Pike</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Jan. 3. 1968</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Western Star</u>		23d. LOCATION (City, town or county) (State) <u>Catonsville Maryland</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Stetson D. Wilson</u> 1913 W. Baltimore St.		25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE <u>Charles J. J...</u>	





16473

## CERTIFICATE OF DEATH

16473

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Towson</b>		c. LENGTH OF STAY IN TB <b>2.6455</b>		2. USUAL RESIDENCE (Where deceased lived, if institut on Res before admission) a. STATE <b>Maryland</b> b. COUNTY <b>D</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore 21234</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>ST. JOSEPH HOSPITAL</b>				d. STREET ADDRESS <b>1734 Red Oak Rd.,</b>	
3. NAME OF DECEASED (Type or print) <b>Halbert J. COLVIN</b>		4. DATE OF DEATH Month <b>December</b> Day <b>22</b> Year <b>19 67</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 15, 1908</b>		9. AGE (In years last birthday) <b>59</b> yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Guard</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>	
13. FATHER'S NAME <b>Samuel Colvin</b>			14. MOTHER'S MAIDEN NAME <b>Laura Phillips</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>215-09-2013</b>		17. INFORMANT Address <b>Catherine C. Colvin, 1734 Red Oak Rd.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral hemorrhage</b> DUE TO <b>hypertension</b> (b) <b>Terminal broncho-pneumonia.</b> DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>12/20/</b> , 19 <b>67</b> , to <b>12/22/</b> , 1967, that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>12/22/</b> , 19 <b>67</b> , and that death occurred at <b>4 P.M.</b> , from causes and on the date stated above.					
22a. SIGNATURE <i>Dr. Gualberto C. Gokim, Jr.</i> M.D.			22b. DATE SIGNED <b>12/22/67</b>		
22c. PHYSICIAN'S NAME (Type) <b>Gualberto C. Gokim, Jr.</b>			22d. ADDRESS <b>7620 York Rd., Towson, Md. 21204</b>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>12-26-1967</b>		23c. NAME OF CEMETERY OR CREMATORY <b>New Cathedral,</b>	
				23d. LOCATION (City or Town) (County) (State) <b>Baltimore, Md.</b>	
24. FUNERAL DIRECTOR ADDRESS <b>Wm. Cook-Brooks Towson, Towson, Md.</b>			25a. REC'D BY REGISTRAR DATE <b>DEC 28 1967</b>		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



## CERTIFICATE OF DEATH

16472

1 PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>TOWSON</b> c. LENGTH OF STAY IN 1b <b>(1001 W. Joppa Rd.) Baltimore 21204</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>ST. JOSEPH HOSPITAL</b>		2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>(1001 W. Joppa Rd.) Baltimore 21204</b> d. STREET ADDRESS <b>1001 W. Joppa Rd.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) <b>SISTER MARY BERNARDINE, M.H.S.H. (CONLON)</b>		4 DATE OF DEATH Month <b>December</b> Day <b>26</b> Year <b>19 67</b>	
5 SEX <b>Female</b>	6 COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb. 23, 1893</b>
9. AGE (In years last birthday) <b>74</b> yrs		IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Nun</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Convent</b>	
11 BIRTHPLACE (County & State, or foreign country) <b>New York, N.Y.</b>		12 CITIZEN OF WHAT COUNTRY? <b>New York, N.Y.</b>	
13. FATHER'S NAME <b>William Conlon</b>		14. MOTHER'S MAIDEN NAME <b>Bridget Clark</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO <b>none</b>	
17. INFORMANT <b>Convent Records, 1001 W. Joppa Rd. Towson</b>		Address	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Congestive Heart Failure</b> DUE TO (b) <b>Arteriosclerotic Heart Disease</b> DUE TO (c) <b>Thromboembolism, Thrombophlebitis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last		INTERVAL BETWEEN ONSET AND DEATH	
PART II: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour <b>19</b> a.m. <input type="checkbox"/> p.m. <input type="checkbox"/>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>December 25 19 67</b> to <b>Dec. 26, 19 67</b> that (I) (we) lost the deceased alive on <b>December 26 19 67</b> , and that death occurred at <b>3:05 AM</b> , from causes and on the date stated above.			
22a. SIGNATURE <b>Dr. Ismael Jamora, M.D.</b>		22b. DATE SIGNED <b>12-26-67</b>	
22c. PHYSICIAN'S NAME (Type) <b>Dr. Ismael Jamora, M.D.</b>		22d. ADDRESS <b>7620 York Rd., Towson, Md. 21204</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>12/28/1967</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Convent Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>1001 W. Joppa Rd. Towson, Md.</b>	
24. FUNERAL DIRECTOR <b>Mr. Vernon Kemmer</b>		25a. REC'D BY REGISTRAR <b>DEC 28 1967</b>	
ADDRESS <b>4611 Park Heights Av. Balto. Md.</b>		25b. REGISTRAR'S SIGNATURE <b>Walter J. Judge</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

1648-1

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

16473

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Mount Wilson</b>		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b>	
c. LENGTH OF STAY IN 1b <b>5 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Accokeek</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Mount Wilson State Hospital</b>		d. STREET ADDRESS <b>Rt. 2 Box 184</b>	
3. NAME OF DECEASED (Type or print) <b>BERNARD WEBSTER COOK</b>		4. DATE OF DEATH Month <b>12</b> Day <b>6</b> Year <b>1967</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>7-4-1886</b>
9. AGE (In years last birthday) yrs. <b>81</b>		IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>TOBACCO</b>	
11. BIRTHPLACE (County & State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>WILLIAM COOK</b>		14. MOTHER'S MAIDEN NAME <b>MARIAN WEBSTER</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>213-383332</b>	
17. INFORMANT <b>Records, Mt. Wilson State Hospital</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>PULMONARY EMBOLI</b> DUE TO (b) <b>Arteriosclerotic heart disease</b> DUE TO (c) <b>10 years</b>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Far advanced pulmonary tuberculosis</b>		19. WAS A TOLPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>12-1-1967</b> , to <b>12-6-1967</b> , that (I) (we) lost saw the deceased alive on <b>12-6-1967</b> , and that death occurred at <b>3:30 PM</b> , from causes and on the date stated above.			
22a. SIGNATURE <b>William Newcomer</b>		22b. DATE SIGNED <b>12.6.67.</b>	
22c. PHYSICIAN'S NAME (Type) <b>William Newcomer, M.D., Superintendent Mount Wilson, Maryland</b>		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>12-9-67</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>ST MARYS Cem</b>		23d. LOCATION (City or Town) (County) (State) <b>PISCATAWAY, P.G., MD.</b>	
24. FUNERAL DIRECTOR <b>Shirley Funeral Home, Waldorf, Md.</b>		25a. REC'D BY REG STRAR <b>DATE DEC 11 1967</b>	
25b. REG STRAR'S SIGNATURE <b>Charles Judge</b>			



1  
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
1648  
13474  
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Baltimore		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN ID		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md.		b. COUNTY Balto.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 6739 Brookmont Dr.						d. STREET ADDRESS 6739 Brookmont Dr.					
3. NAME OF DECEASED (Type or print)		First ENRICO		Middle CORRELLI		Last		4. DATE OF DEATH Dec. 7 1967		19	
5. SEX Male		6. COLOR OR RACE Cauc.		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH Feb. 14, 1883		9. AGE (In years last birthday) 84 yrs.		10. FUNERAL YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Asst. Foreman		10b. KIND OF BUSINESS OR INDUSTRY Railroad		11. BIRTHPLACE (County & State, or foreign country) Italy		12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Giaconio Correlli		14. MOTHER'S MAIDEN NAME ??	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 717-07-6427		17. INFORMANT Mr. Herman Correlli		Address 6739 Brookmont Dr.		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial insufficiency DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arterio sclerosis and diabetes DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH one year	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)	
21. I certify that (I) (this hospital) attended the deceased from November, 1967, to Dec, 1967, that (I) (we) last saw the deceased alive on 6 Dec 1967, and that death occurred at 1:30 P.M. from the causes and on the date stated above.											
22a. SIGNATURE S E Proctor M.D.		22b. DATE SIGNED 8 Dec 67		22c. PHYSICIAN'S NAME (Type) S E Proctor M.D.		22d. ADDRESS 104 W. Madison St 21201		22e. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22f. ATTENDING PHYS. <input checked="" type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12/11/67		23c. NAME OF CEMETERY OR CREMATORY Most Holy Redeemer Cem.		23d. LOCATION (City, town or county) Balto. City, Md.		23e. REC'D BY REGISTRAR		23f. REGISTRAR'S SIGNATURE NFC 11 1967	
24. FUNERAL DIRECTOR Wm. Cook-Brooks, Inc. 1217 St. Paul St.						24a. REC'D BY REGISTRAR					





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

10480  
10475  
M  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

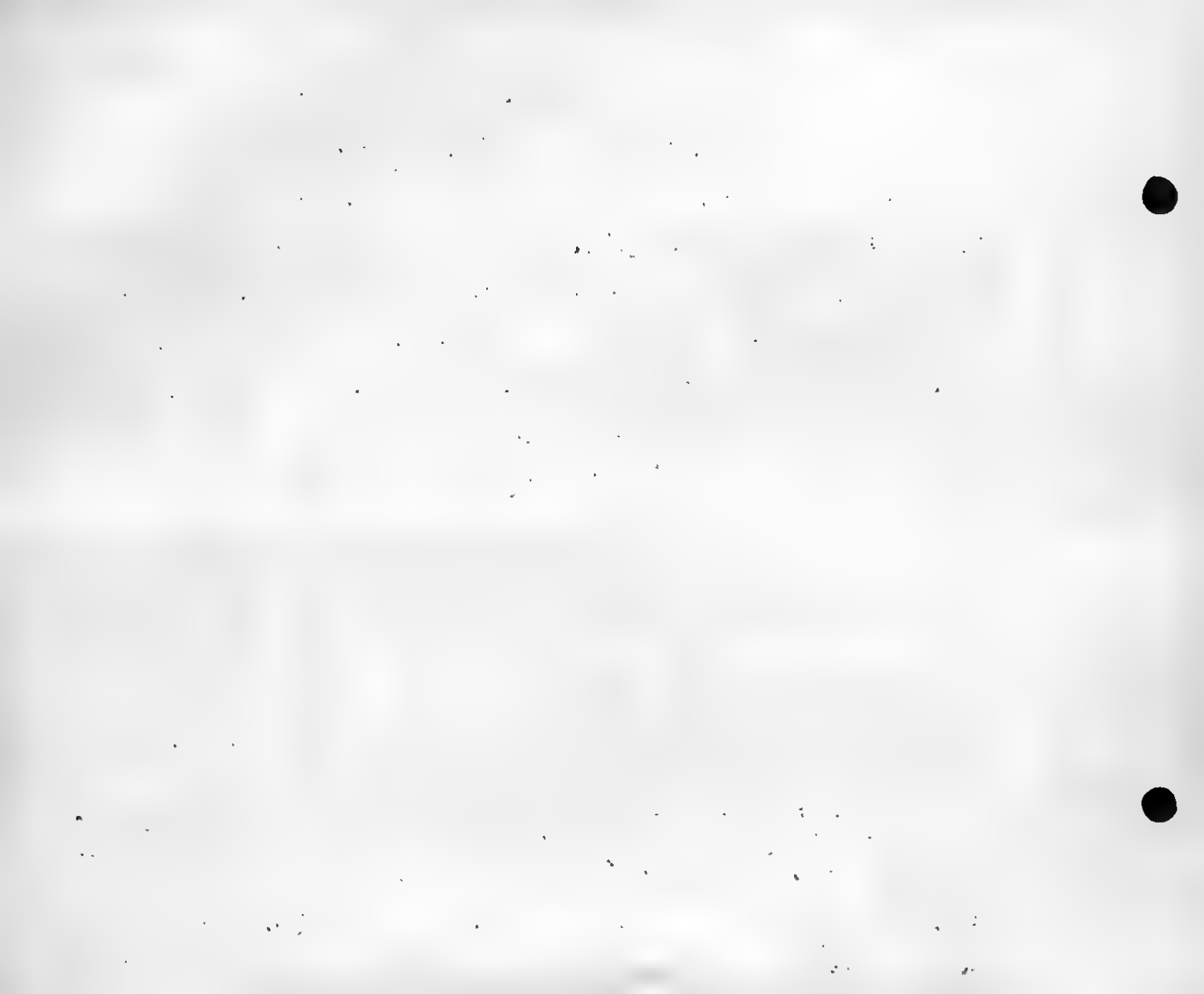
1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bradshaw</u>		c. LENGTH OF STAY IN 1b <u>58</u> years	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bradshaw</u>		d. STREET ADDRESS <u>Reynolds Road</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>none</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Catherine Gladys Creswell</u>		4. DATE OF DEATH <u>Dec. 26</u> 19 <u>67</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 5, 1903</u>
9. AGE (In years last birthday) <u>64</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Supr. Gas Mask Prod.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Govt- Ret.</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Jonna, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John Burke</u>		14. MOTHER'S MAIDEN NAME <u>Addie Gordon</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u>220-20-7068</u>	
17. INFORMANT <u>Albert B. Creswell, Reynolds Rd., Bradshaw</u>		Address <u>Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arterio Sclerosis</u> (c) <u>Hypertension</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Aug.</u> , 19 <u>62</u> to <u>Dec.</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>Dec. 11</u> , 19 <u>67</u> , and that death occurred at <u>M</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>William A. Tyson</u>		22b. DATE SIGNED <u>12-26-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>William A. Tyson</u>		22d. ADDRESS <u>Kingsville Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		23b. DATE THEREOF <u>Dec. 27, 1967</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Bel Air Memorial Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Bel Air Harford Md</u>	
24. FUNERAL DIRECTOR <u>Howard K. McConas &amp; Son, Abingdon, W. 21009</u>		25a. REC'D BY REGISTRAR <u>DEC 29 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>W. E. Young</u>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

16483		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201		16476					
1 DECEASED-NAME (Type or print) First Middle Last Joseph G. Daniel				2a DATE OF DEATH Month Day Year Dec. 28 1967		2b HOUR 7:00 A.M.			
3. SEX Male		4. RACE White		5. DATE OF BIRTH June 18, 1914		6. AGE (In years last birthday) 53 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (State or foreign country) N.C.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Baltimore Md.			
10. CITY OR TOWN OF DEATH Randallstown		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 33 Sheraton Rd.		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Electrical Engineer		12b. KIND OF BUSINESS OR INDUSTRY Electric			
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE Md.		13b. COUNTY Baltimore		13c. CITY OR TOWN Randallstown		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER 33 Sheraton Rd.	
14. FATHER'S NAME First Middle Last Leland - Daniel		15. MOTHER'S MAIDEN NAME First Middle Last Maggie Lee Windbourne							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No		16b. SOCIAL SECURITY NO. 218-01-8082		17. INFORMANT Mrs Gladys Daniel		Address Randallstown, Md.			
18. CAUSE OF DEATH (Enter any one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> 4-1-1 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Atherosclerosis</u> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH. 30 min									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME FARM STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <u>Nov</u> , 1967, to <u>Dec. 28</u> , 1967, that (I) (we) lost saw the deceased alive on <u>Dec. 28</u> , 1967, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>Wm. E. Martin M.D.</u>				DEGREE <input checked="" type="checkbox"/> ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 12-28-67			
22d. PHYSICIAN'S NAME (Type) Wm. E. MARTIN, M.D.				22e. ADDRESS Randallstown Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 12-31-67		23c. NAME OF CEMETERY OR CREMATORY Wards Chapel		23d. LOCATION (City or Town) (County) (State) Randallstown Md.			
24. FUNERAL DIRECTOR Harry W. Haight				ADDRESS Sykesville, Md.		25a. REC'D BY REGISTRAR DATE JAN 3 1968		25b. REGISTRAR'S SIGNATURE Hollands Judge	



Items 23c Film G397 2/7/68 kk

## CERTIFICATE OF DEATH

16477

1 PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institut on Residence before admission) a. STATE <b>Maryland</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. LENGTH OF STAY IN lb <b>35yrlmth16dys</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>SPRING GROVE STATE HOSPITAL</b>		d. STREET ADDRESS <b>2827 East Chase Street</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3 NAME OF DECEASED (Type or print) <b>Walter</b> First Middle Last		4 DATE OF DEATH <b>December 26</b> Month Day Year	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb. 14, 1914</b>
9. AGE (in years lost birthday) <b>53</b> yrs		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>painter</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>Frederick Danker</b>		14. MOTHER'S MAIDEN NAME <b>Hattie Amelia Grubbs</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Records: SPRING GROVE STATE HOSPITAL</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH CAUSED BY IMMEDIATE CAUSE (a) <b>Suppurative Abscess.</b> DUE TO <b>Metastatic Ca.</b> DUE TO <b>Transitory Cold Cough/Asphyxiation.</b> CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), stating the underlying cause last			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that <del>the</del> (this hospital) attended the deceased from <b>Oct. 29</b> , 19 <b>32</b> , to <b>12/26</b> , 19 <b>67</b> , that <del>the</del> (we) last saw the deceased alive on <b>12/26</b> , 19 <b>67</b> , and that death occurred at <b>1054</b> A.M., from causes and on the date stated above.			
22a. SIGNATURE <b>Robert Fisher</b>		22b. DATE SIGNED <b>12/26/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>Robert Fisher</b>		22d. ADDRESS <b>SPRING GROVE STATE HOSPITAL Baltimore, Maryland 21228</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY <b>Anatomy Board of Md.</b>	23d. LOCATION (City or Town) (County) (State)
24. FUNERAL DIRECTOR ADDRESS		25a. RECD. BY REGISTRAR DATE <b>JAN 5 1968</b>	
		25b. REGISTRAR'S SIGNATURE <b>James J. [Signature]</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



## CERTIFICATE OF DEATH

16487

16478

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>  </u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL TOWSON</u>		c. LENGTH OF STAY IN 1b <u>20 DAYS</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Greater Baltimore Medical Center</u>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BALTIMORE</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>WALTER JAMES DAVIS</u>		4. DATE OF DEATH Month Day Year <u>December 12 1967</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6-06-86</u>
9. AGE (In years lost birthday) yrs <u>81</u>		10. IF UNDER 1 YEAR Months Days Hours Min IF UNDER 24 HRS	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>WORK IN COAL MINES</u>		10b. KIND OF BUSINESS OR IND. STRY <u>Retired</u>	
11. BIRTHPLACE (County & State or foreign country) <u>ARCHIBALD PENNA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>FRANK DAVIS</u>		14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>UNKNOWN</u>		16. SOCIAL SECURITY NO <u>057-34-2619</u>	
17. INFORMANT <u>M. FABISZAK</u>		Address <u>G.B.M.C.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cardio-respiratory failure</u> DUE TO (b) <u>Extreme carcinoma, lung, left</u> DUE TO (c) <u>  </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost			INTERVAL BETWEEN ONSET AND DEATH
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (this hospital)-attended the deceased from <u>Nov. 23</u> , 19 <u>67</u> , to <u>Dec. 12</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>Dec. 12</u> , 19 <u>67</u> , and that death occurred at <u>3:40 AM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Marlean S. Termini</u>		22b. DATE SIGNED <u>Dec. 12, 67</u>	
22c. PHYSICIAN'S NAME (Type) <u>ANASTACIA FABIE</u>		22d. ADDRESS <u>G.B.M.C. - 6701 N Charles St.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>12-15-67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Prospect Hill Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>PECKVILLE, LACKAWANNA CO., PA.</u>
24. FUNERAL DIRECTOR <u>Wm. Cook-Brooks Inc.</u>		25a. REC'D BY REGISTRAR <u>1217 St. Paul St.</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		DATE <u>DEC 15 1967</u>	





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

1648		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201		CERTIFICATE OF DEATH		16479	
1 PLACE OF DEATH a COUNTY <b>Baltimore</b> MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a STATE <b>Maryland</b> b COUNTY <b>Prince George's</b>			
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c LENGTH OF STAY IN 1b <b>3mth27dys</b>		c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hillsdie, Maryland</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>SPRING GROVE STATE HOSPITAL</b>				d STREET ADDRESS <b>1222 - 53rd Avenue</b>		e RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) <b>George William DeBinder Sr.</b>				4 DATE OF DEATH Month <b>December</b> Day <b>4</b> Year <b>1967</b>			
5 SEX <b>male</b>		6 COLOR OR RACE <b>white</b>		7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8 DATE OF BIRTH <b>Sept. 5, 1908</b>	
9 AGE (in years last birthday) yrs <b>59</b>		IF UNDER 1 YEAR Months Days Hours Min.		10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>painter</b>		10b KIND OF BUSINESS OR INDUSTRY <b>Construction</b>	
11 BIRTHPLACE (County & State or foreign country) <b>Illinois</b>				12 CITIZEN OF WHAT COUNTRY? <b>U. S. A</b>			
13. FATHER'S NAME <b>George W. DeBinder</b>				14 MOTHER'S MAIDEN NAME <b>Libby Stanton</b>			
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>yes</b>		16 SOCIAL SECURITY NO <b>1928-1932</b>		17. INFORMANT <b>Records: SPRING GROVE STATE HOSPITAL</b>			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. <b>471X</b> IMMEDIATE CAUSE (a) <b>Aspiration pneumonia</b> DUE TO (b) DUE TO (c)				INTERVA. BETWEEN ONSET AND DEATH			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				19 WAS ALZOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of item 18)					
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)	
21. I certify that (X) (this hospital) attended the deceased from <b>Aug. 7, 1967</b> to <b>Dec. 4, 1967</b> , that (X) (we) last saw the deceased alive on <b>Dec. 4, 1967</b> , and that death occurred on <b>Dec. 4, 1967</b> at <b>p.</b> M, from causes on and on the date stated above.							
22a SIGNATURE <b>Anthony G. Young, M.D.</b>				22b DATE SIGNED <b>12-4-67</b>		22c PHYSICIAN'S NAME (Type)	
22d ADDRESS <b>SPRING GROVE STATE HOSPITAL Baltimore, Maryland 21228</b>							
23a BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b DATE THEREOF <b>12/8/67</b>		23c NAME OF CEMETERY OR CREMATORY <b>Baltimore National</b>		23d LOCATION (City or Town) (County) (State) <b>Baltimore, Baltimore Md.</b>	
24. FUNERAL DIRECTOR <b>Francis Gasch's Sons Hyattsville, Md.</b>				25a. REC'D BY REGISTRAR DATE <b>DEC 11 1967</b>		25b REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

SHIPPED TO: L. W. HERRING FUNERAL HOME, 15 MAIN ST. SMITHFIELD, VIRGINIA

MEDICAL CERTIFICATION

1 PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FORT HOWARD</b> c. LENGTH OF STAY IN lb <b>14 DAYS</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>VETERANS ADMINISTRATION HOSPITAL</b>		2 USUAL RESIDENCE (Where deceased lived, if institution Res dence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>BALTIMORE</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BALTIMORE - 21222</b> d. STREET ADDRESS <b>209 MAIN STREET</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) <b>GEORGE N. DELK</b> First Middle Last 4 DATE OF DEATH <b>DECEMBER 8 19 67</b> Month Day Year 5 SEX <b>MALE</b> 6 COLOR OR RACE <b>NEGRO</b> 7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <b>9/7/99</b> 9 AGE (In years last birthday) <b>68</b> yrs IF UNDER 1 YEAR Months Days IF UNDER 24 HRS Hours Min			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>LABORER</b> 10b. KIND OF BUSINESS OR INDUSTRY <b>CONSTRUCTION</b> 11. BIRTHPLACE (County & State, or foreign country) <b>ISLE OF WRIGHT COUNTY, VIRGINIA U.S.A.</b> 12 CITIZEN OF WHAT COUNTRY?			
13 FATHER'S NAME <b>RUBEN DELK</b> 14. MOTHER'S MAIDEN NAME <b>IDA CORNER</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>YES WW I</b> 16. SOCIAL SECURITY NO <b>216 10 17 27</b> 17. INFORMANT <b>CLIN.RECORDS, VA HOSPITAL, FT HOWARD, MD.</b> Address			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>BRONCHOPNEUMONIA</b> DUE TO (b) <b>CEREBRAL VASCULAR ACCIDENT, CLINICAL</b> DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last INTERVAL BETWEEN ONSET AND DEATH <b>RECENT</b> <b>RECENT</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) <b>ARTERIOSCLEROTIC HEART DISEASE. ADENOCARCINOMA RIGHT KIDNEY</b> 19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) 20c. TIME OF INJURY Month, Day, Year Hour o m p.m. <b>19</b> 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) 20f. (City or town) (County) (State)			
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>11/24/67</b> , 19__, to <b>12/8/67</b> , 19__, that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>12/6/67</b> 19__, and that death occurred at <b>2:10 AM</b> on causes and on the date stated above.			
22a. SIGNATURE <b>John D. Talbert</b> 22b. DATE SIGNED <b>12/8/67</b> M.D. ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/> 22c. PHYSICIAN'S NAME (Type) <b>JOHN D. TALBERT, M. D.</b> 22d. ADDRESS <b>VAH FORT HOWARD, MARYLAND</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b> 23b. DATE THEREOF <b>12-12-67</b> 23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Sinai Bapt. Ch. Cem. Smithfield, Va.</b> 23d. LOCATION (City or Town) (County) (State) 24. FUNERAL DIRECTOR <b>MORTEN &amp; DYETTE FUNERAL HOME</b> ADDRESS <b>1701 LAURENS ST. BALTIMORE, MD.</b> 25a. REC'D BY REGISTRAR <b>11 1967</b> 25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VI-145 (4)  
30M REV 1/68

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
16481									
1 DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH			2b HOUR
Annie			MARIAN			Dec. 31, 1967			M
3 SEX		4 RACE		5 DATE OF BIRTH		6 AGE (In years last birthday)		IF UNDER 1 YEAR	
Female		White		Feb. 23, 1888		79 YRS.		MONTHS DAYS HOURS MIN.	
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Md.		U. S. A.				Baltimore Md.			
10. CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY
Randallstown			Liberty Road			Housewife			U. S. A.
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET AND NUMBER
Md.			Baltimore		Randallstown				Liberty Road
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME						
First Middle Last			First Middle Last						
William A. Crooks			Elizabeth - Claggett						
16a. WAS DECEASED EVER IN U. S. ARMED FORCES? Yes, no, or unknown			16b SOCIAL SECURITY NO		17. INFORMANT Address				
No					MR. J. HARMON Crooks - Randallstown, Md				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY:									
IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u>									75 hr
DUE TO, OR AS A CONSEQUENCE OF									
(b) <u>Atherosclerosis</u>									
DUE TO, OR AS A CONSEQUENCE OF									
(c)									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
					YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, nat'lly medical examiner)		21b TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
		HOUR A.M. Month Day Year P.M. 19							
21d INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION					
While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>				Street or R.F.D. No City or Town County State					
22a I certify that (I) (this hospital) attended the deceased from 1946 to 12/31/1967, that (I) (we) last saw the deceased alive on 12/31/1967, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE		22c. DATE SIGNED							
Wm. E. Martin M.D.									
22d. PHYSICIAN'S NAME (Type)		22e ADDRESS							
Wm. E. Martin, M.D.		Randallstown Md							
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		1-3-68		Wards Chapel Cemetery		Baltimore County, Md.			
24. FUNERAL DIRECTOR		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
Harry W. Wright		Sykesville, Md.		DATE JAN 5 1968		Charles J. J...			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

VR A15 (4)  
25M 1/67

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, and file them with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Towson</b>						2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>ST. JOSEPH HOSPITAL</b>						d. STREET ADDRESS <b>601 E. Joppa Rd.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First Middle Last <b>Alice ALSTON DEVASHER</b>						4. DATE OF DEATH Month Day Year <b>December 19, 19 67</b>					
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>March 31, 1887</b>		9. AGE (In years last birthday) <b>80</b> yrs		IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Homemaker</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>Kansas CITY, MISSOURI</b>			12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
13. FATHER'S NAME <b>William ALSTON</b>						14. MOTHER'S MAIDEN NAME <b>CATHERINE O'BRIEN</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO <b>?</b>		17. INFORMANT Address <b>Wm. A. DeVasher 14 W. Cold Spring LA.</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Broncho-pneumonia of both lungs</b> DUE TO <b>Acute Peritonitis, rupture of diverticulum of</b> <b>* * * the colon</b> DUE TO (c)											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>12/18/</b> 19 <b>67</b> to <b>12/19/</b> 19 <b>67</b> that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>12/19/</b> 19 <b>67</b> , and that death occurred at <b>2:15 PM</b> , from causes on and on the date stated above.											
22a. SIGNATURE <b>I. Cilliani</b>						M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>			22b. DATE SIGNED <b>12/19/67</b>		
22c. PHYSICIAN'S NAME (Type) <b>I. Cilliani, M.D.</b>						22d. ADDRESS <b>7620 York Rd., Towson, Md. 21204</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>CREMATION</b>		23b. DATE THEREOF <b>12-23-67</b>		23c. NAME OF CEMETERY OR CREMATORY <b>GREEN MOUNT CREMATORY</b>				23d. LOCATION (City or Town) (County) (State) <b>BALTO. Md.</b>			
24. FUNERAL DIRECTOR ADDRESS <b>Wm. Cook - Brooks, Inc. 1217 ST. PAUL ST.</b>						25a. REC'D BY REGISTRAR DATE <b>DEC 20 1967</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

16487

16482





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

<div>16483</div> <div>MARYLAND STATE DEPARTMENT OF HEALTH</div> <div>DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</div> <div>CERTIFICATE OF DEATH</div> <div>16483</div>									
1. PLACE OF DEATH a. COUNTY <i>Baltimore</i> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>1</i>				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Baltimore</i>			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Baltimore</i>				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>6702 Linden Avenue</i>					d. STREET ADDRESS <i>6702 Linden Avenue</i>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>Florence E.</i> Middle <i>Dieter</i> Last			4. DATE OF DEATH Month <i>Dec.</i> Day <i>30</i> Year <i>1967</i>						
5. SEX <i>Female</i>		6. COLOR OR RACE <i>White</i>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>June 29, 1915</i>		9. AGE (In years last birthday) <i>52</i> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>housewife</i>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <i>Baltimore, Maryland</i>			12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>John Cook</i>					14. MOTHER'S MAIDEN NAME <i>Mary Pfarr</i>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16. SOCIAL SECURITY NO. (If yes give war or dates of service)		17. INFORMANT <i>John Dieter - 6702 Linden Ave. - 21206</i>			Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute myocardial infarction</i> DUE TO (b) <i>Arteriosclerotic cardio-vascular</i> DUE TO (c) <i>disease</i>								INTERVAL BETWEEN ONSET AND DEATH <i>1 hr.</i> <i>4 yrs.</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)									
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <i>Feb 29, 1966</i> to <i>Dec 30, 1967</i> , that (I) (we) last saw the deceased alive on <i>Dec 18, 1967</i> , and that death occurred at <i>11:15 PM</i> , from the causes and on the date stated above.									
22a. SIGNATURE <i>Charles M. Kerr</i>								22b. DATE SIGNED <i>12-31-67</i>	
22c. PHYSICIAN'S NAME (Type) <i>Charles M. Kerr</i>					22d. ADDRESS <i>6801 Belair Rd Baltimore, Md.</i>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>			23b. DATE THEREOF <i>1-3-68</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Gardens of Faith Cemetery</i>		23d. LOCATION (City, town or county) (State) <i>Balto. Md.</i>		
24. FUNERAL DIRECTOR <i>John C. Miller Inc-6415 Belair Rd.-21206</i>					25a. REC'D BY REGISTRAR <i>JAN 8 1968</i>		25b. REGISTRAR'S SIGNATURE <i>J. Charles Judge</i>		



MDARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

16484

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 PLACE OF DEATH a. COUNTY <b>BALTO.</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Howard Co.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>RURAL BALTO.</b>		c. LENGTH OF STAY IN <b>10 years</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Greater BALTO. Medical Center</b>		d. STREET ADDRESS <b>1 Woodview Road</b>	
3 NAME OF DECEASED (Type or print) <b>Stephen CHARLES DiStefano</b>		4. DATE OF DEATH Month <b>December</b> Day <b>11</b> Year <b>1967</b>	
5 SEX <b>M</b>	6 COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>10-19-20</b>
10a US. OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Self-employed</b>		10b KIND OF BUSINESS OR INDUSTRY <b>Filling Station</b>	9 AGE (In years last birthday) <b>47</b> yrs
11 BIRTHPLACE (County & State, or foreign country) <b>BALTIMORE - Md.</b>		12 CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>	
13. FATHER'S NAME <b>CHARLES DiStefano</b>		14. MOTHER'S MAIDEN NAME <b>Mary L. Catanzarher</b>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>YES WW II</b>		16 SOCIAL SECURITY NO. <b>220-06-1490</b>	
17 INFORMANT <b>Helen K. DiStefano - same</b>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Carcinoma, lung &amp; diffuse metastases</b> 163x DUE TO (b) <b>72 months</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. <b>11:47 p.m.</b> Dec. 11 1967		20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)	
21. I certify that <b>he</b> (this hospital) attended the deceased from <b>December 2, 1967</b> , to <b>December 11, 1967</b> , that (I) (we) last saw the deceased alive on <b>December 11, 1967</b> , and that death occurred at <b>11:47 p.m.</b> M, from causes and on the date stated above.			
22a SIGNATURE <b>Charlene E. Fabre</b>		22b DATE SIGNED <b>Dec. 11, 1967</b>	
22c PHYSICIAN'S NAME (Type) <b>ANASTACIA E. FABIZ</b>		22d ADDRESS <b>GREATER BALTIMORE Med. CENTER</b>	
23a BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>12/15/67</b>	23c NAME OF CEMETERY OR CREMATORY <b>Baltimore Mt. Cem.</b>	23d LOCATION (City or Town) (County) (State) <b>Baltimore, Md.</b>
24. FUNERAL DIRECTOR <b>Witke F. D. - 4101 Edmondson Av.</b>		25a REC'D BY REGISTRAR <b>DEC 14 1967</b>	
		25b REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



11



12

13

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1, and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16492

Items 8 & 9 Film G397 2/6/68

CERTIFICATE OF DEATH

17838

1 PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>WICOMICO</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FORT HOWARD</b>		c. LENGTH OF STAY IN 1b <b>8 DAYS</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>VETERANS ADMINISTRATION HOSPITAL</b>		e. STREET ADDRESS <b>515 PRISCILLA STREET</b>	
3 NAME OF DECEASED (Type or print) First <b>ARTHUR</b> Middle <b>THOMAS</b> Last <b>DIX</b>		4 DATE OF DEATH Month <b>DECEMBER</b> Day <b>3</b> Year <b>19 67</b>	
5 SEX <b>MALE</b>	6 COLOR OR RACE <b>WHITE</b>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>12 6 67 1892</b>
9 AGE (In years last birthday) <b>72 74 yrs</b>		10. IF UNDER 1 YEAR Months <b>72</b> Days <b>74</b> Hours <b>00</b> Min <b>00</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>CARPENTER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>PARKSLEY, VIRGINIA</b>	
11 BIRTHPLACE (County & State, or foreign country) <b>U.S.A.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>JOHN W. DIX</b>		14. MOTHER'S MAIDEN NAME <b>JBANETTE WESSELLS</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>YES WW-1</b>		16. SOCIAL SECURITY NO <b>225 18 3216</b>	
17 INFORMANT <b>CLIN. REC., VAH, FT. HOWARD, MD.</b>		Address	
18 CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>PNEUMONIA</b> DUE TO (b) <b>CARCINOMA OF THE PROSTATE</b> CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)		INTERVAL BETWEEN ONSET AND DEATH <b>RECENT</b> <b>UNKNOWN</b>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART (a)		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.		20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)	
21 I certify that <b>NO</b> (this hospital) attended the deceased from <b>Nov. 25 19 67</b> to <b>Dec. 3 19 67</b> that <b>XX</b> (we) last saw the deceased alive on <b>Dec. 3 19 67</b> , and that death occurred at <b>12:10 PM</b> , from causes and on the date stated above.			
22a SIGNATURE <b>Henry M. Johnson M.D.</b>		ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/> 22b DATE SIGNED <b>12/3/67</b>	
22c PHYSICIAN'S NAME (Type) <b>ISABELITA Y CORDOBA</b>		22d ADDRESS <b>VAH, FORT HOWARD, MARYLAND</b>	
23a BURIAL, CREMATION, REMOVAL (Specify)	23b DATE THEREOF <b>12/19/67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Parksley Cemetery</b>	23d. LOCATION (City or Town) (County) (State) <b>PARKSLEY, VIRGINIA</b>
24 FUNERAL DIRECTOR <b>Henry Johnson Funeral Home</b>		ADDRESS <b>Parksley, Virginia</b>	
25a REC'D BY REGISTRAR <b>FEB 2 1968</b>		25b REGISTRAR'S SIGNATURE <b>[Signature]</b>	



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 10-103. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item 11 Film G396 1/16/68 kr

16493

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

16485

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Dundalk</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Dundalk</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>2903 Liberty Parkway</b>		d. STREET ADDRESS <b>2903 Liberty Parkway</b>	
3. NAME OF DECEASED (Type or print) <b>Margaret Celestia Dohner</b>		4. DATE OF DEATH Month <b>December</b> Day <b>30</b> Year <b>1967</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 15, 1898</b>
9. AGE (in years last birthday) <b>69</b> yrs		10. UNDER 1 YEAR Months Days IF UNDER 24 HRS Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>At home</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Penna.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Clark Helwig</b>		14. MOTHER'S MAIDEN NAME <b>Grace/Adams Edwards</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO <b>216-54-6010</b>	
17. INFORMANT <b>Abraham S. Dohner</b>		Address <b>2903 Liberty Parkway</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cornary Occlusion</b> DUE TO <b>Rheumatic Carditis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) (c) PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>None</b>		INTERVAL BETWEEN ONSET AND DEATH <b>—</b>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DEATH BY INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. pm 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>M.B. Davis</b>		22. DATE SIGNED	
EXAMINER'S NAME (Type) <b>M.B. Davis, M.D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street city town, or county) <b>6800 Mornington Rd.</b>	
23a. BURIAL (CREMATION REMOVAL) (Specify) <b>Burial</b>	23b. DATE THEREOF <b>1/3/68</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Crestlawn Gardens</b>	23d. LOCATION (City or town) (County) (State) <b>Baltimore, Maryland</b>
24. FUNERAL DIRECTOR <b>Ulrich Funeral Home Dundalk, Md.</b>		25a. REC'D BY REGISTRAR DATE <b>JAN 5 1968</b>	
		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

15ME (5)  
68 1/67





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1 PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institut on Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <input checked="" type="checkbox"/>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c LENGTH OF STAY IN lb <b>Hours</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Spring Grove State Hospital</b>		d STREET ADDRESS <b>18 North Mount Street</b>	
3 NAME OF DECEASED (Type or print) <b>Helen J. Dorsey</b>		4 DATE OF DEATH <b>December 12 1967</b>	
5 SEX <b>Female</b>	6. COLOR OR RACE <b>Negro</b>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>Jan. 22, 1897</b>
9. AGE (In years last birthday) <b>70</b> yrs		10 IF UNDER 1 YEAR Months Days Hours Min.	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None DOMESTIC</b>		10b KIND OF BUSINESS OR INDUSTRY <b>PUT FAMILY</b>	
11 BIRTHPLACE (County & State or foreign country) <b>Maryland</b>		12 CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13 FATHER'S NAME <b>ARDE Johnson</b>		14 MOTHER'S MAIDEN NAME <b>CHRISTINA HOWARD</b>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>NO</b>		16 SOCIAL SECURITY NO <b>219-10-0900</b>	
17 INFORMANT <b>Records: Spring Grove</b>		Address	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I DEATH CAUSED BY IMMEDIATE CAUSE (a) <b>Pneumonia, Bronchial, Right Lower Lobe</b> 471X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) DUE TO (c)		INTERVA. BETWEEN ONSET AND DEATH <b>3 days</b>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Arteriosclerotic Cardiovascular Rt. Dis with congestive failure</b>		19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d INJURY OCCURRED While <input type="checkbox"/> hot While <input type="checkbox"/> of work of work	20e PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)	20f (City or town) (County) (State)
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>Dec. 11, 1967</b> to <b>Dec. 12, 1967</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>Dec. 12, 1967</b> , and that death occurred at <b>7:00 PM</b> , from causes and on the date stated above			
22a SIGNATURE <b>Anthony J. Young, M.D.</b>		22b DATE SIGNED <b>Dec. 13, 1967</b>	
22c PHYSICIAN'S NAME (Type) <b>Anthony J. Young, M.D.</b>		22d ADDRESS <b>Spring Grove State Hospital Baltimore, Maryland 21228</b>	
23a BURIAL, CREMATION, REMOVAL (Specify)	23b DATE THEREOF <b>12/15/67</b>	23c NAME OF CEMETERY OR CREMATORY <b>not known</b>	23d LOCATION (City or Town) (County) (State) <b>Baltimore</b>
24 FUNERAL DIRECTOR <b>Marion P. Hann 638 E. Calumet St</b>		25a REC'D BY REGISTRAR <b>DEC 14 1967</b>	25b REGISTRAR'S SIGNATURE <b>[Signature]</b>



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1649 MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
16487  
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE (TOWSON)</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>---</b>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b <b>52 hr 15 min</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>GREATER BALTIMORE MEDICAL CENTER</b>		d. STREET ADDRESS <b>2026 W FAYETTE STREET</b>	
3. NAME OF DECEASED (Type or print) First <b>James</b> Middle <b>Grafton</b> Last <b>Dorsey, III</b>		4. DATE OF DEATH Month <b>12</b> Day <b>24</b> Year <b>1967</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>NEGRO</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>12-22-67</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>NONE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>NONE</b>	9. AGE (In years last birthday) yrs. <b>2</b> Months <b>4</b> Days <b>15</b>
11. BIRTHPLACE (County & State, or foreign country) <b>BALTO. MD</b>		12. CITIZEN OF WHAT COUNTRY? <b>UNITED STATES</b>	
13. FATHER'S NAME <b>James Grafton Dorsey, Jr.</b>		14. MOTHER'S MAIDEN NAME <b>BALEFOOT</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>NONE</b>	
17. INFORMANT <b>INFANT BIRTH INFORMATION</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Shock + respiratory arrest + pneumonia</b> DUE TO (b) <b>Myocardial infarction - intestinal necrosis</b> DUE TO (c) <b>Ruptured aneurysm - congenital</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Peritonitis</b>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m. <b>---</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>12/22</b> , 19 <b>67</b> to <b>12/24</b> , 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>12/24</b> , 19 <b>67</b> , and that death occurred at <b>9:35 PM</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>James Grafton Dorsey, III</b>		22b. DATE SIGNED <b>12/24/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>James Grafton Dorsey, III</b>		22d. ADDRESS <b>---</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>12-28-67</b>		23b. DATE THEREOF <b>12-28-67</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Mount Airy</b>		23d. LOCATION (City, town or county) (State) <b>Baltimore MD</b>	
24. FUNERAL DIRECTOR <b>Mr. Thomas A. Hemmley</b>		25a. REC'D BY REGISTRAR <b>JAN 3 1968</b>	
25b. REGISTRAR'S SIGNATURE <b>James Grafton Dorsey, III</b>		25c. DATE <b>---</b>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2, and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

16496

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

18486

1 PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville Manor</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville Manor</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>5901 Montgomeryst.</u>		d. STREET ADDRESS <u>5901 Montgomeryst.</u>	
3 NAME OF DECEASED (Type or print) First <u>Maud</u> Middle <u>T.</u> Last <u>Drain</u>		4 DATE OF DEATH Month <u>Dec.</u> Day <u>19</u> Year <u>1967</u>	
5 SEX <u>F</u>	6 COLOR OR RACE <u>Cauc.</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>June 7, 1877</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) yrs <u>90</u>
11. BIRTHPLACE (County & State, or foreign country) <u>Baltimore, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Harry Houck</u>		14. MOTHER'S MAIDEN NAME <u>Mary McClymont</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Mrs. Lela Simpson</u>		Address <u>5901 Montgomeryst.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> DUE TO (b) <u>Arteriosclerosis Cerebral</u> DUE TO (c) <u></u>			INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>10 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u></u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>Sept 9, 1947</u> to <u>12/19, 1967</u> , that (I) (we) last saw the deceased alive on <u>12/18, 1967</u> , and that death occurred at <u></u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>John P. Urlock Jr</u>		22b. DATE SIGNED <u>12/19/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>John P. Urlock, Jr.</u>		22d. ADDRESS <u>1227 Washington Blvd.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>12/22/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Drauid Ridge Cem.</u>	23d. LOCATION (City or Town) (County) (State) <u>Baltimore, Md.</u>
24. FUNERAL DIRECTOR <u>witzke F. D. - 4101 Hammond Ave.</u>		25a. RECD BY REGISTRAR DATE <u>DEC 21 1967</u>	
		25b. REGISTRAR'S SIGNATURE <u>John P. Urlock Jr</u>	



DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

16497

CERTIFICATE OF DEATH

16489

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>CATONSVILLE</b> c. LENGTH OF STAY IN b. <b>MARYLAND</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>1018 MARKS WORTH ROAD</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>BALTIMORE</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>CATONSVILLE</b> d. STREET ADDRESS <b>1018 MARKS WORTH ROAD</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>MICHAEL DUFFY</b> First Middle Last		4. DATE OF DEATH <b>DEC. 29 1967</b> Month Day Year			
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>DEC. 4 1869</b>		9. AGE (In years last birthday) <b>98</b> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>BLO. R.R.</b>		11. BIRTHPLACE (County & State, or foreign country) <b>IRELAND</b>	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes give year or dates of service)		17. INFORMANT Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <b>Cerebral Thrombosis</b> DUE TO (b) <b>Arteriosclerotic Cardio-vascular Disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					INTERVAL BETWEEN ONSET AND DEATH <b>5</b> days years
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)		(State)	
21. I certify that (I) <b>(the hospital)</b> attended the deceased from <b>May 1961</b> to <b>Dec. 1967</b> , that (I) <b>(we)</b> saw the deceased alive on <b>Jan. 28 1967</b> , and that death occurred at <b>4:30</b> from the causes and on the date stated above.					
22a. SIGNATURE <b>[Signature]</b>		22b. DATE SIGNED <b>12/29/67</b>		22c. PHYSICIAN'S NAME (Type) <b>Leo J. Gaver, M.D.</b>	
22d. ADDRESS <b>1 Mallow Hill Ave., Baltimore, Md.</b>		22e. REC'D BY REGISTRAR <b>[Signature]</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>JAN. 3 1968</b>		23c. NAME OF CEMETERY OR CREMATORY <b>NEW CATHEDRAL</b>	
23d. LOCATION (City, town or county) <b>BALTO. MARYLAND</b>		23e. REGISTRAR'S SIGNATURE <b>[Signature]</b>			
24. FUNERAL DIRECTOR'S SIGNATURE <b>[Signature]</b>		ADDRESS <b>4101 EDMONDSON BALTO.</b>		25. REC'D BY REGISTRAR <b>[Signature]</b>	





16498

## CERTIFICATE OF DEATH

16498

1 PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a STATE <u>Maryland</u> b COUNTY <u></u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Randallstown</u>		c. LENGTH OF STAY IN TB <u>2 days</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>BALTIMORE COUNTY GENERAL HOSP.</u>		d. STREET ADDRESS <u>116 W. Martin St.</u>	
3 NAME OF DECEASED (Type or print) <u>Oneita</u> First <u>S.</u> Middle <u>Eckerley</u> Last		4. DATE OF DEATH Month <u>12</u> Day <u>19</u> Year <u>1967</u>	
5 SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>7-4-1888</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>	9. AGE (in years last birthday) <u>79</u> yrs
11. BIRTHPLACE (County & State or foreign country) <u>PA.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Robert Sechrist</u>		14. MOTHER'S MAIDEN NAME <u>Emma Kemp</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or Unknown) (If yes give war or dates of service) <u>NO</u>		16 SOCIAL SECURITY NO. <u>913-61-7545</u>	
17 INFORMANT <u>Daughter</u>		Address <u>Woodstock - Md.</u> <u>Coranite Mobile Ct.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>MYOCARDIAL INFARCTION</u> DUE TO (b) <u>ARTERIOSCLEROTIC HEART DISEASE</u> DUE TO (c) <u></u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diffuse edema + acute passive congestion of lungs</u>			19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <u>(Choking)</u>	
20c TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>Dec. 17, 1967</u> , to <u>Dec. 19, 1967</u> , that (I) (we) last saw the deceased alive on <u>Dec. 14, 1967</u> , and that death occurred at <u>8:00 P.M.</u> , from causes and on the date stated above.			
22a SIGNATURE <u>Graciano V. Patricio</u>		22b DATE SIGNED <u>Dec. 19, 1967</u>	
22c. PHYSICIAN'S NAME (Type) <u>Graciano V. PATRICIO</u>		22d. ADDRESS	
23a BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>DEC. 23, 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>WHATNOT CEM.</u>	23d LOCATION (City or Town) (County) (State) <u>SNOW HILL, MD.</u>
24. FUNERAL DIRECTOR <u>Deane's Funeral Home, Inc.</u>		25a. REC'D BY REGISTRAR <u>DEC 26 1967</u>	
25b REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 2 and 3, and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
16490 CERTIFICATE OF DEATH 16491											
1. PLACE OF DEATH a. COUNTY <b>BALTO</b> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institut on Residence before admission) a. STATE <b>MD</b> b. COUNTY <b>BALTO</b>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>ESSEX</b>				c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outs de corporate limits, write RURAL and give nearest town) <b>ESSEX</b>					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>213 S. TAYLOR</b>						d. STREET ADDRESS <b>213 S. TAYLOR</b>				e. RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>MILDRED C. EDELL</b>						4. DATE OF DEATH <b>DEC. 24 1967</b>					
5. SEX <b>F</b>		6. COLOR OR RACE <b>W</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>DEC. 21 1892</b>		9. AGE (In years lost birthday) <b>75</b> yrs		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>BALTO. MD</b>				12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>ANDREW STUCKRATH</b>						14. MOTHER'S MAIDEN NAME <b>ELIZ. ROSE</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>NO</b>				16. SOCIAL SECURITY NO. <b>216-096178</b>		17. INFORMANT <b>ALBERT EDELL</b> Address <b>ABOVE</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>443X</b> <b>Circulatory failure</b> DUE TO <b>Heart failure, chronic</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } DUE TO <b>Hypertensive Cardiovascular disease</b> (c) <b>Years.</b>										INTERVAL BETWEEN ONSET AND DEATH <b>2 days.</b> <b>2 months.</b> <b>Years.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>probably cancer of unknown origin.</b>										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>April 12, 1964</b> to <b>December 23, 1967</b> , that (I) (we) last saw the deceased alive on <b>December 23, 1967</b> , and that death occurred at <b>1 P.M.</b> from causes and on the date stated above											
22a. SIGNATURE <b>Eugene C. Baumann</b>						ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED <b>12-26-67</b>			
22c. PHYSICIAN'S NAME (Type) <b>Eugene C. Baumann</b>						22d. ADDRESS <b>413 Eastern Ave. Baltimore 21, Md</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>12/28/67</b>		23c. NAME OF CEMETERY OR CREMATORY <b>DAK LAWN</b>				23d. LOCATION (City or Town) (County) (State) <b>BALTO. MD</b>			
24. FUNERAL DIRECTOR <b>J.G. CONNELLY SONS</b> ADDRESS <b>300 MACE</b>						25a. REC'D BY REGISTRAR <b>DEC 28 1967</b>		25b. REGISTRAR'S SIGNATURE <b>Richard Jones</b>			



## CERTIFICATE OF DEATH

1650J

16492

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY <u>BALTO</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>BALTO.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CATONSVILLE</u>		c. LENGTH OF STAY IN Td <u>15 MRS.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>SHANGRI-LA-HOME</u>		d. STREET ADDRESS <u>17 BRIARWOOD RD.</u>	
3 NAME OF DECEASED (Type or print) <u>ELSIE</u> First Middle Last <u>O. Ehlers</u>		4 DATE OF DEATH Month <u>Dec</u> Day <u>25</u> Year <u>1967</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11/11/83</u>
9. AGE (In years last birthday) <u>84</u> yrs		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Alfred H. Milburn</u>		14. MOTHER'S MAIDEN NAME <u>Emily J.</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>-</u>	
17. INFORMANT <u>Ralph M. Ehlers</u>		Address <u>17 BRIARWOOD RD 21228</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Chronic Uremia</u> <u>+46X</u> DUE TO (b) <u>Nephrosclerosis</u> DUE TO (c) <u>Hypertension</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Glaucoma - Diabetes - Fresh G.I. Bleeding</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)
20f. (City or town) (County) (State)		20g. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>1-6-</u> , 19 <u>67</u> , to <u>12-25-</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>12-26-1967</u> , and that death occurred at <u>      </u> M, from causes and on the date stated above			
22a. SIGNATURE <u>Cesar Valle Caverio</u>		22b. DATE SIGNED <u>12-26-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>CESAR VALLE CAVERO</u>		22d. ADDRESS <u>8629 Liberty Rd.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>12/28/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>WOODLAWN CEM</u>	23d. LOCATION (City or Town) (County) (State) <u>BALTO. Co. Md.</u>
24. FUNERAL DIRECTOR <u>C.S. MacNabb</u>		25a. REC'D BY REGISTRAR <u>Catonsville Md 21228</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		DATE <u>JAN 2 1968</u>	



16501 Item 9 Film G396 1/2 inch

CERTIFICATE OF DEATH

16493

1 PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonville</b>		c. LENGTH OF STAY IN TB <b>1 yr 10 mos</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Forest Haven Nursing Home</b>		d. STREET ADDRESS <b>Gun Road</b>	
3 NAME OF DECEASED (Type or print) <b>Theodore Eichhorn</b>		4 DATE OF DEATH Month <b>12</b> Day <b>17</b> Year <b>1967</b>	
5 SEX <b>Male</b>	6 COLOR OR RACE <b>White</b>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>11-26-1884</b>
9 AGE (In years last birthday) <b>82</b> yrs		IF UNDER 1 YEAR Months <b>12</b> Days <b>17</b> Hours <b>19</b> Min <b>67</b>	
10a. US. AL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Bldg Construction</b>	
11 BIRTHPLACE (County & State, or foreign country) <b>St. Louis Missouri</b>		12 CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13 FATHER'S NAME <b>Otto Eichhorn</b>		14 MOTHER'S MAIDEN NAME <b>Maria Wolfe</b>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>		16 SOCIAL SECURITY NO <b>218-18-2147</b>	
17 INFORMANT <b>Marguerite Leutner</b>		Address <b>7320 Windsor Mill Rd.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>MYOCARDIAL INFARCTION</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) <b>ARTERIO SCLEROTIC CORONARY VASCULOPATHY</b> DUE TO (c) <b>DISEASE</b>			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <b>19</b>	20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>3/14</b> , 19 <b>66</b> , to <b>24/17</b> , 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>24/17</b> , 19 <b>67</b> , and that death occurred at <b>10</b> M, from causes and on the date stated above			
22a SIGNATURE <b>Dr. John H. Shaw</b>		22b DATE SIGNED <b>12/18/67</b>	
22c PHYSICIAN'S NAME (Type) <b>Dr. John H. Shaw</b>		22d ADDRESS <b>5800 Edmondson Avenue Balto Md.</b>	
23a BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b DATE THEREOF <b>12/19/67</b>	23c NAME OF CEMETERY OR CREMATORY <b>Lorraine Park Cemetery</b>	23d LOCATION (City or Town) (County) (State) <b>Woodlawn Balto Md.</b>
24 FUNERAL DIRECTOR <b>Loring Byers 8728 Liberty Rd Randallstown</b>		25a RECD BY REGISTRAR DATE <b>DEC 26 1967</b>	25b REGISTRAR'S SIGNATURE <b>Charles Judge</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VS A111 (4)  
25M 1/67

<div style="text-align: center;"> <p>16502</p> <p>DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201</p> <p>Item 21c 111-3186 1/9/68 KK</p> <p><b>CERTIFICATE OF DEATH</b></p> <p style="text-align: right;">16494</p> </div>									
<b>1. PLACE OF DEATH</b> a. COUNTY <u>Baltimore</u> MARYLAND					<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>			c. LENGTH OF STAY IN lb <u>39yr 4mth</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>SPRING GROVE STATE HOSPITAL</u>					d. STREET ADDRESS <u>1525 Clement Street</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) <u>Julia</u>					4. DATE OF DEATH Month <u>December</u> Day <u>1</u> Year <u>1967</u>				
5. SEX <u>female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1888</u>		9. AGE (in years last birthday) <u>79</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State or foreign country) <u>Hungary</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		
13. FATHER'S NAME					14. MOTHER'S MAIDEN NAME				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)			16. SOCIAL SECURITY NO. <u>219-54-3107T</u>		17. INFORMANT Address <u>Records: SPRING GROVE STATE HOSPITAL</u>				
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c)) <u>undetermined</u> PART I DEATH CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia, Left Lower Lobe, org.</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Metastatic carcinoma, probable</u> DUE TO (c) <u>Carcinoma of the left breast, probable</u>									INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>  <u>1 month</u>  <u>2 months</u>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes Mellitus; Hypertensive, Carteriosclerotic CVHD</u>									19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part I of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (1) (this hospital) attended the deceased from <u>Aug. 1, 1967</u> to <u>Dec. 1, 1967</u> that (2) (we) last saw the deceased alive on <u>Dec. 1, 1967</u> , and that death occurred at <u>11:30</u> M, from causes and on the date stated above									
22a. SIGNATURE <u>Anthony J. Young, M.D.</u>					22b. DATE SIGNED <u>12-1-67</u>				
22c. PHYSICIAN'S NAME (Type) <u>Anthony J. Young, M.D.</u>					22d. ADDRESS <u>SPRING GROVE STATE HOSPITAL</u> <u>Baltimore, Maryland 21228</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY <u>Anatomy Board of Md.</u>			23d. LOCATION (City or town) (County) (State)		
24. FUNERAL DIRECTOR ADDRESS					25a. REC'D BY REGISTRAR DATE <u>DEC 11 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.  
Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1-2-68 mt 16503		MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201		CERTIFICATE OF DEATH		15495	
1 PLACE OF DEATH a COUNTY Baltimore MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a STATE Maryland b COUNTY			
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson		c LENGTH OF STAY IN 1b		c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 21212		e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St. Joseph Hospital				d STREET ADDRESS 5646 Govane Ave.			
3 NAME OF DECEASED (Type or print) First Middle Last Ralph William Engle				4 DATE OF DEATH Month Day Year December 20 19 67			
5 SEX Male	6 COLOR OR RACE White	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH August 25, 1905	9 AGE (In years lost birthday) 62 yrs	IF UNDER 1 YEAR Months Days Hours Min		IF UNDER 24 HRS Hours Min
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman		10b KIND OF BUSINESS OR INDUSTRY Avis Truck Rental		11. BIRTHPLACE (County & State, or foreign country) Pennsylvania		12 CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Charles C. Engle				14. MOTHER'S MAIDEN NAME Laura ?			
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16 SOCIAL SECURITY NO (If yes give war or dates of service) --- 166-01-0233		17 INFORMANT Mary M. Engle (Wife)		Address Same	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: 451X IMMEDIATE CAUSE (a) Ruptured aortic aneurysm DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e PLACE OF INJURY (Home, farm, factory, street, office bldg, etc)		20f (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from Dec. 13, 19 67, to Dec. 20, 19 67, that (I) (we) last saw the deceased alive on Dec. 20, 19 67, and that death occurred at 11:40, from causes and on the date stated above.							
22a SIGNATURE Lucas C. Vidhyaphum M.D.				ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b DATE SIGNED PM 12-20-67	
22c PHYSICIAN'S NAME (Type) Lucas C. Vidhyaphum, M.D.				22d ADDRESS 7620 York Rd., Towson, Md. 21204			
23a BURIAL, CREMATION, REMOVAL (Specify) Burial	23b DATE THEREOF 12/23/1967	23c NAME OF CEMETERY OR CREMATORY Moreland Memorial Park		23d LOCATION (City or Town) (County) (State) Baltimore, Md.			
24 FUNERAL DIRECTOR Eugenia K. Seitz Seitz Funeral Home				25a REC'D BY REGISTRAR DEC 26 1967		25b REGISTRAR'S SIGNATURE Charles Judge	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 4 and 5, and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16504

CERTIFICATE OF DEATH

16496

PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c LENGTH OF STAY IN 1b	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>PROFESSIONAL HOUSE, 133 SLADE AVENUE</b>		d STREET ADDRESS <b>3900 N. CHARLES STREET</b>	
3 NAME OF DECEASED (Type or print) First <b>FLORA</b> Middle <b>B.</b> Last <b>ENNIS</b>		4. DATE OF DEATH Month <b>DECEMBER</b> Day <b>27</b> Year <b>1967</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>OCTOBER 9, 1888</b>
9 AGE (In years last birthday) <b>79</b> yrs.		10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>	
10b KIND OF BUSINESS OR INDUSTRY <b>AT HOME</b>		11 BIRTHPLACE (County & State, or foreign country) <b>BALTIMORE, MARYLAND</b>	
12 CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>ALEXANDER BECKHOFFER</b>	
14. MOTHER'S MAIDEN NAME <b>REBECCA STRAUS</b>		15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>NO</b>	
16. SOCIAL SECURITY NO <b>213-12-8907</b>		17. INFORMANT <b>MR. PAUL PALMBAUM, 6701 PARK HIGHTS. AVE.</b>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Systemic thrombosis of middle cerebral artery - original thrombosis - 4 weeks prior to death</b> DUE TO (b) <b>Arteriosclerotic cerebrovascular Disease - see page</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>3 min</b>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part I. of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>8/20, 1953</b> to <b>12/27, 1967</b> , that (I) (we) last saw the deceased alive on <b>12/21, 1967</b> , and that death occurred at <b>1:30 PM</b> , from causes and on the date stated above			
22a. SIGNATURE <i>[Signature]</i>		22b. DATE SIGNED <b>12/28/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>Dr. J. ELLIOT LEVI</b>		22d. ADDRESS <b>222 W. COLD SPRING LANE</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE THEREOF <b>12-28-67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>DRUID RIDGE</b>	23d. LOCATION (City or Town) (County) (State) <b>BALTIMORE, MARYLAND</b>
24. FUNERAL DIRECTOR <b>SOL LEVINSON &amp; BROS., INC., 6010 REISTERSTOWN ROAD</b>		25a. REC'D BY REGISTRAR <b>JAN 2 1968</b>	25b. REGISTRAR'S SIGNATURE

VR A15 (4)  
25M 11/67



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15-1  
20 M 1-66

MARYLAND STATE DEPARTMENT OF HEALTH									
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
16503					CERTIFICATE OF DEATH			16497	
1 PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND					2 USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural - Baltimore</b>			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>1209 Overbrook Road</b>					d. STREET ADDRESS <b>1209 Overbrook Road</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>LENA</b> Middle <b>H.</b> Last <b>EVANS</b>					4. DATE OF DEATH Month <b>December</b> Day <b>15</b> Year <b>1967</b>				
5 SEX <b>Female</b>		6 COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8 DATE OF BIRTH <b>Aug. 10, 1895</b>		9 AGE (In years last birthday) <b>72</b> yrs	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>			10b. KIND OF BUSINESS OR INDUSTRY		11 BIRTHPLACE (County & State, or foreign country) <b>Switzerland</b>			12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Robert Allard</b>					14. MOTHER'S MAIDEN NAME <b>Unk.</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>			16 SOCIAL SECURITY NO <b>None</b>		17 INFORMANT <b>Mrs. Magdalene Behr</b>			Address <b>(Same)</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of Pancreas</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <b>with metastasis to abd lymphatics</b> (b) DUE TO (c) DUE TO								INTERVAL BETWEEN ONSET AND DEATH <b>8 mos &amp; 10 days</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Hypertension C-V disease</b>								19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <b>Dec 12, 1967</b> to <b>Dec 15, 1967</b> , that (I) (we) last saw the deceased alive on <b>Dec 12, 1967</b> , and that death occurred at <b>2:30 PM</b> , from causes and on the date stated above.									
22a. SIGNATURE <b>H. K. Harbold</b> M.D.					ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>Dec 16, 1967</b>		
22c. PHYSICIAN'S NAME (Type) <b>H. K. HARBOLD MD</b>					22d. ADDRESS <b>4700 Harford Road Baltimore, Md.</b>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			23b. DATE THEREOF <b>12/18/67.</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Parkwood Cemetery</b>			23d. LOCATION (City or town) (County) (State) <b>Baltimore, Md.</b>	
24 FUNERAL DIRECTOR <b>Leonard J. Ruck, Inc. Balto. Md. 21214</b>					25a. REC'D BY REGISTRAR DATE <b>DEC 18 1967</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		





MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

16506

16494

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Parkville</b>		c. LENGTH OF STAY IN life <b>life</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Parkville</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>2706 Taylor avenue</b>				d. STREET ADDRESS <b>2706 Taylor avenue</b>		e. RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>MARGARET</b> Middle <b>EVANS</b> Last				4. DATE OF DEATH Month <b>Dec</b> Day <b>31</b> Year <b>1967</b>			
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb 9 1877</b>	9. AGE (in years last birthday) <b>90 yrs</b>	IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>At home</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>John Meis</b>				14. MOTHER'S MAIDEN NAME <b>Margaret *****</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO <b>None</b>		17. INFORMANT Address <b>Family records</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral hemorrhage</b> 351X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Cerebral arteriosclerosis</b> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <b>1 hr.</b> <b>20 yrs</b>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS A TOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Jan 5, 1959</b> , to <b>Dec. 31, 1967</b> , that (I) (we) last saw the deceased alive on <b>Dec. 31 1967</b> , and that death occurred at <b>5:00 P.M.</b> from causes and on the date stated above.							
22a. SIGNATURE <b>[Signature]</b>				M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED <b>1/2/68</b>	
22c. PHYSICIAN'S NAME (Type) <b>S. Elliot Harris M.D.</b>				22d. ADDRESS <b>8100 Hafford Rd.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>1/3/68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Carmel Cem.</b>		23d. LOCATION (City or Town) (County) (State) <b>Baltimore, Maryland</b>	
24. FUNERAL DIRECTOR <b>C.F. EVANS &amp; SON 8802 Harford road</b>				25a. REC'D BY REGISTRAR <b>DATA 3 1968</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>	



16507

16499

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Parkville, Md.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Parkville - 21234</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>2611 Putty Hill Rd. Apt "6"</b>		d. STREET ADDRESS <b>2611 Putty Hill Rd.</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>HARRY</b> Middle <b>LAMBERT</b> Last <b>FADER</b>		4. DATE OF DEATH Month <b>December</b> Day <b>28</b> , Year <b>1967</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb. 8, 1892</b>
9. AGE (In years last birthday) <b>75</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Plant Manager</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Retired</b>	11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
13. FATHER'S NAME <b>Charles Fader</b>		14. MOTHER'S MAIDEN NAME <b>Minnie Bahr</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO <b>216-05-9488</b>	
17. INFORMANT <b>Mrs. Fannie Fader-2611 Putty Hill Rd.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute dilatation of the heart</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Hypertensive cardiovascular renal disease</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL CONDITION GIVEN IN PART I (a)			
INTERVAL BETWEEN ONSET AND DEATH <b>0</b> <b>4 months</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>September</b> , 19 <b>67</b> , to <b>Dec. 28</b> , 19 <b>67</b> , that I last saw the deceased alive on <b>December 28</b> , 19 <b>67</b> , and that death occurred at <b>11 a.</b> M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>516 Cathedral St., Baltimore, Md.</b> DATE SIGNED <b>12/29/67</b> ACTUAL SIGNATURE <b>Ernest Marr, M.D.</b> PHYSICIAN'S NAME (Type) <b>Ernest Marr, M.D.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Jan. 2, 1968</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Moreland Mem. Park</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>H. Sander &amp; Sons, Inc., Balto., Md.</b>		24a. REC'D BY REGISTRAR <b>JAN 2 1968</b>	
24b. REGISTRAR'S SIGNATURE			

MEDICAL CERTIFICATION

TO HOSPITAL OR NURSING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

16503

16500

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Codd Convalescent Home</u>				d. STREET ADDRESS <u>7914 Knollwood Road</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Thea Gertrude Farley</u>				4. DATE OF DEATH Month Day Year <u>December 15, 1967</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>November 2, 1891</u>		9. AGE (In years last birthday) <u>76</u> yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John A. McArthur</u>				14. MOTHER'S MAIDEN NAME <u>Alice Shannessy</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Family records</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CEREBRAL HEMORRHAGE</u> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							INTERVAL BETWEEN ONSET AND DEATH <u>6 MOS.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> DR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>AUG 10, 1967</u> to <u>DEC 15, 1967</u> , that (I) (we) last saw the deceased alive on <u>DEC 14, 1967</u> and that death occurred at <u>1:30</u> M., from the causes and on the date stated above.							
22a. SIGNATURE <u>T. C. Siwinski</u>				22b. DATE SIGNED <u>12/18/67</u>		22c. PHYSICIAN'S NAME (Type) <u>T. C. SIWINSKI</u>	
22d. ADDRESS <u>206 W. PENNA AVE TOWSON MD.</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Dec 18, 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Holy Redeemer Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Baltimore, Maryland</u>	
24. FUNERAL DIRECTOR <u>John Burns' Sons, Towson, Maryland</u>				25a. REC'D BY REGISTRAR DATE <u>DEC 21 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

MEDICAL CERTIFICATION



16509

## CERTIFICATE OF DEATH

16501

1 PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Parkville</b>		c. LENGTH OF STAY IN 1b <b>Baltimore 21234</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>8402 Beryl Road</b>		e. STREET ADDRESS <b>8402 Beryl Road</b>	
3 NAME OF DECEASED (Type or print) First <b>ETHEL</b> Middle <b>MARIE</b> Last <b>FEETE</b>		4. DATE OF DEATH Month <b>December</b> Day <b>4</b> Year <b>19 67.</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 29, 1912.</b>
9. AGE (In years last birthday) <b>55</b> yrs		10. IF UNDER 1 YEAR Months <b>12</b> Days <b>19</b> Hours <b>67.</b>	
11. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) <b>Retired C. &amp; P. Telephone Co.</b>		12. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>	
13. FATHER'S NAME <b>George Andrews</b>		14. MOTHER'S MAIDEN NAME <b>Estelle Benson</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO <b>212-03-6957</b>	
17. INFORMANT <b>Mr. Vernon Feete</b>		Address <b>(Same)</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Carcinoma, overmen with metastases</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c)		INTERVAL BETWEEN ONSET AND DEATH <b>1960 (74)</b>	
PART II: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>None</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>1953</b> , 19 <b>12.3</b> , 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>12.3</b> 19 <b>67</b> , and that death occurred at <b>5:20 PM</b> , from causes and on the date stated above.			
22a. SIGNATURE <b>Dr. Joseph Skloven</b>		22b. DATE SIGNED <b>12.4 67</b>	
22c. PHYSICIAN'S NAME (Type) <b>Dr. Joseph Skloven</b>		22d. ADDRESS <b>7122 Harford Road</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>12/7/67.</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Moreland Memorial Cemetery</b>	23d. LOCATION (City or Town) (County) (State) <b>Baltimore, Md.</b>
24. FUNERAL DIRECTOR <b>Leonard J. Ruck, Inc. Balto. Md. 21214</b>		25. REC'D BY REGISTRAR <b>DEC 5 1967</b>	
		25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.





# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## CERTIFICATE OF DEATH

16510

16502

1 PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND			2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FORT HOWARD</b>		c. LENGTH OF STAY IN 1b <b>3 DAYS</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BALTIMORE</b>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>VETERANS ADMINISTRATION HOSPITAL</b>			d. STREET ADDRESS <b>112 SCOTT STREET</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <b>NOBLE ELZAPHION FISHER</b>			4. DATE OF DEATH Month Day Year <b>DECEMBER 15 1967</b>		
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>NEGROID</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>5/12/25</b>		9. AGE (In years last birthday) yrs <b>42</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>LABORER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>STEEL</b>	11. BIRTHPLACE (County & State or foreign country) <b>GRASONVILLE, MD</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>ALBERT FISHER</b>			14. MOTHER'S MAIDEN NAME <b>ARRIE BOWLING</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>YES WWII</b>		16. SOCIAL SECURITY NO. <b>218 20 6821</b>	17. INFORMANT Address <b>CLIN. RECORDS, VA HOSPITAL, FT HOWARD, MD</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>CANCER OF ESOPHAGUS</b> <b>150 X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH <b>MONTHS</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)		
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>12/12/67</b> , 19__, to <b>12/15/67</b> 19__, that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>12/15/67</b> , 19__, and that death occurred at <b>7:30 PM</b> , from causes and on the date stated above.					
22a. SIGNATURE <i>George Dudas</i> M.D.			ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <b>12/16/67</b>
22c. PHYSICIAN'S NAME (Type) <b>GEORGE DUDAS, MD</b>			22d. ADDRESS <b>VA HOSPITAL, FORT HOWARD, MD</b>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>Dec 20, 1967</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Baltimore, Maryland</b>	
24. FUNERAL DIRECTOR <b>Wm. March Funeral Home</b>		ADDRESS <b>928 E. North Ave. Baltimore, Maryland</b>		25a. REC'D BY REGISTRAR <b>DEC 18 1967</b>	25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## CERTIFICATE OF DEATH

16503

16511

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b>		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Balto.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. LENGTH OF STAY IN lb <b>3mths.18dys</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore, 21222 Maryland</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Spring Grove State Hospital</b>		d. STREET ADDRESS <b>2151 Coralhorn Road</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Star</b>		First Middle Last <b>Flanagan</b>		4. DATE OF DEATH Month Day Year <b>Dec. 26 1967</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>Jan. 20, 1912</b>	9. AGE (In years last birthday) <b>55 yrs.</b>	IF UNDER 1 YEAR Months Days Hours Min. <b>26 1967</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & state or foreign country) <b>West Virginia</b>	
13. FATHER'S NAME <b>Russell Martin</b>		14. MOTHER'S MAIDEN NAME <b>Mary Varner</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO <b>214-07-5558</b>		17. INFORMANT <b>Records: Spring Grove State Hospital</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: <b>150.1</b> IMMEDIATE CAUSE (a) <b>Metastatic, well differentiated adeno-</b> DUE TO (b) <b>the gastrointestinal tract, probable</b> DUE TO (c) <b>Well differentiated adenocarcinoma, from</b>		INTERVAL BETWEEN ONSET AND DEATH <b>6 months</b> <b>6 months</b>			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)	
20f. (City or town)		(County)		(State)	
21. I certify that (X) (this hospital) attended the deceased from <b>Sept. 8, 1967</b> , to <b>Dec. 26, 1967</b> , that (X) (we) last saw the deceased alive on <b>Dec. 26, 1967</b> , and that death occurred at <b>5:00M.</b> from causes and on the date stated above.					
22a. SIGNATURE <i>Anthony J. Young</i>		P. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <b>Anthony J. Young, M.D.</b>		22d. ADDRESS <b>Spring Grove State Hospital Baltimore, Maryland 21228</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>DEC. 30, 1967</b>		23c. NAME OF CEMETERY OR CREMATORY <b>FLANAGAN CEMETERY</b>	
23d. LOCATION (City or Town) <b>DRY FORK</b>		(County)		(State) <b>W. VA.</b>	
24. FUNERAL DIRECTOR <b>BYRON KIGHT</b>		ADDRESS <b>CUMBERLAND, MD.</b>		25a. REC'D BY REGISTRAR DATE <b>JAN 3 1968</b>	
				25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 4 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201			
16512		CERTIFICATE OF DEATH	
1 PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Baltimore</u>	c. LENGTH OF STAY IN 1b <u>16 yrs</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Balto.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>6004 Charlesmead Rd.</u>		d. STREET ADDRESS <u>6004 Charlesmead Rd.</u>	
3 NAME OF DECEASED (Type or print) <u>Elizabeth M. Folckner</u>		4. DATE OF DEATH Month <u>Dec</u> Day <u>26</u> Year <u>1967</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct 16 1926</u>
9. AGE (In years last birthday) <u>41</u> yrs.		10. IF UNDER 1 YEAR Months <u>10</u> Days <u>10</u> Hours <u>10</u> Min <u>10</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Nurse</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>NURSING</u>	
11 BIRTHPLACE (County & State or foreign country) <u>Springfield, Ohio</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Samuel S. Folckner</u>		14. MOTHER'S MAIDEN NAME <u>Ann Harper</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>Yes 1917-18</u>		16. SOCIAL SECURITY NO. <u>275-30-649</u>	
17. INFORMANT <u>Bernice T. Wainwright</u>		Address <u>6004 Charlesmead Rd.</u>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Insufficiency</u> DUE TO (b) <u>Arteriosclerotic cardio-vascular disease</u> DUE TO (c) <u></u>		INTERVAL BETWEEN ONSET AND DEATH <u>19</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour <u>a.m.</u> p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>December, 1966</u> , to <u>Dec 26, 1967</u> , that (I) (we) last saw the deceased alive on <u>Dec 26, 1967</u> , and that death occurred at <u>12:00 AM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Chas. W. Wainwright</u>		22b. DATE SIGNED <u>12/26/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Chas. W. Wainwright</u>		22d. ADDRESS <u>9 E. Chase St. Baltimore, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>	23b. DATE THEREOF <u>12-26-67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Green Mount</u>	23d. LOCATION (City or Town) (County) (State) <u>Baltimore, Md.</u>
24. FUNERAL DIRECTOR <u>H. W. Jenkins &amp; Sons Co. 4905 York Rd. Balto.</u>		25a. REC'D BY REGISTRAR DATE <u>DEC 27 1967</u>	
		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

16518

16505

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Reisterstown</b>		c. LENGTH OF STAY IN lb <b>4 years</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>107 Lampport Road</b>		d. STREET ADDRESS <b>107 Lampport Road</b>	
3. NAME OF DECEASED (Type or print) <b>Charles Calvin Folkert</b>		4. DATE OF DEATH Month <b>Dec.</b> Day <b>16</b> Year <b>67</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>April 9, 1890</b>
9. AGE (In years last birthday) <b>77</b> yrs		10. IF UNDER 1 YEAR Months <b>1</b> Days <b>16</b> Hours <b>67</b> Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Self-employed</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Grocer</b>	
11. BIRTHPLACE (Country & State, or foreign country) <b>Carroll Co., Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John Folkert</b>		14. MOTHER'S MAIDEN NAME <b>Elizabeth Chritzendahler</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>217-22-9985</b>	
17. INFORMANT <b>John F. Folkert</b>		Address <b>107 Lampport Rd., Reisterstown, Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Carcinoma - lung - right</b> DUE TO (b) DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			
19. INTERVAL BETWEEN ONSET AND DEATH <b>3 months</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE (CONDITION GIVEN IN PART I(c))			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>July</b> , 1967, to <b>December 15</b> , 1967, that (I) (we) last saw the deceased alive on <b>December 15</b> , 1967, and that death occurred at <b>8:05 AM</b> , from causes and on the date stated above			
22a. SIGNATURE <b>Clarence E. McWilliams</b> MD		22b. DATE SIGNED <b>12-17-67</b>	
22c. PHYSICIAN'S NAME (Type) <b>Clarence E. McWilliams MD</b>		22d. ADDRESS <b>11909 Reisterstown Rd. Reisterstown Md</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>12/19/67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Manchester Cemetery</b>	23d. LOCATION (City or Town) (County) (State) <b>Manchester, Carroll, Md.</b>
24. FUNERAL DIRECTOR <b>H.J. Eckhardt</b>		ADDRESS <b>Owings Mills, Md.</b>	
25a. REC'D BY REGISTRAR DATE <b>DEC 20 1967</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

MEDICAL CERTIFICATION





16514

CERTIFICATE OF DEATH

16506

1 PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. LENGTH OF STAY IN <b>3 yrs</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Caton Ridge Nursing Home</b>		d STREET ADDRESS <b>5802 Highgate Drive # 15</b>	
3 NAME OF DECEASED (Type or print) <b>Addella Ford</b>		4. DATE OF DEATH Month <b>Dec</b> Day <b>28</b> Year <b>1967</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb. 9, 1891</b>
9. AGE (In years lost birthday) <b>76</b> yrs		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <b>Balto. Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Daniel Allen</b>		14. MOTHER'S MAIDEN NAME <b>Isabelle Boyer</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>	
17. INFORMANT <b>Mrs Lana L. Milland</b>		<b>5721 Highgate Drive Balto. Md. 21215</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchopneumonia</b> DUE TO (b) <b>Influenza</b> DUE TO (c) <b>Senile - Generalized arteriosclerosis</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Senile - Generalized arteriosclerosis</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>12-1-</b> , 19 <b>66</b> , to <b>12-28-</b> 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>12-28-</b> 19 <b>67</b> , and that death occurred at <b>10 P. M.</b> from causes and on the date stated above			
22a. SIGNATURE <b>Cesar Valle Caven</b>		22b. DATE SIGNED <b>12/29/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>Cesar Valle Caven</b>		22d. ADDRESS <b>8629 Liberty Road Randallstown, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>12/30/67</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Druid Ridge</b>		23d. LOCATION (City or Town) (County) (State) <b>Pikesville, Balt Md</b>	
24. FUNERAL DIRECTOR <b>Waring Myers</b>		25a. REC'D BY REGISTRAR <b>8728 Liberty Rd Randallstown</b>	
25b. REGISTRAR'S SIGNATURE <b>Waring Myers</b>		DATE <b>JAN 2 1968</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon-papers, stamps, and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>C</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Middle River</u>		c. LENGTH OF STAY IN 1b <u>3 1/2</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>		d. STREET ADDRESS <u>2413 Northern Parkway</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Ivy Hall Nursing Home</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>ELSIE</u> Middle <u>M.</u> Last <u>POWKES</u>		4. DATE OF DEATH Month <u>12</u> Day <u>9</u> Year <u>1967</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 14, 1882</u>
9. AGE (In years last birthday) <u>85</u> yrs		10. IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u></u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Penna.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Schrecker</u>		14. MOTHER'S MAIDEN NAME <u>Magdalena Metz</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO <u></u>	
17. INFORMANT <u>Mrs Margaret Croato - Same</u>		Address <u></u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>Coronary thrombosis</u> DUE TO (b) <u>Arteriosclerotic Heart Disease</u> DUE TO (c) <u></u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH <u></u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Cerebral sclerosis</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <u></u>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u></u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u></u>	20f. (City or town) (County) (State) <u></u>
21. I certify that (I) (the deceased) attended the deceased from <u>Dec. 2</u> , 19 <u>67</u> , to <u>Dec. 9</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>Dec. 9</u> , 19 <u>67</u> , and that death occurred at <u>3:50 AM</u> from causes and on the date stated above.			
22a. SIGNATURE <u>Same St. M.D.</u>		22b. DATE SIGNED <u></u>	
22c. PHYSICIAN'S NAME (Type) <u>SAMUEL STERN.</u>		22d. ADDRESS <u>1010 E Belvedere Ave</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>12/13/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Smithfield Cemetery</u>	23d. LOCATION (City or town) (County) (State) <u>Pittsburg Penna.</u>
24. FUNERAL DIRECTOR <u>Leonard J Ruck Inc 5305 Harford Rd</u>		25a. RECD BY REGISTRAR <u>DEC 11 1967</u>	
		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

MEDICAL CERTIFICATION



16516

## CERTIFICATE OF DEATH

16508

1 PLACE OF DEATH a COUNTY <b>Baltimore</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a STATE <b>Maryland</b> b COUNTY <b>Baltimore</b>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c LENGTH OF STAY IN 1b <b>Baltimore</b>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Forest Haven Nursing Home</b>		d STREET ADDRESS <b>1137 Carroll Street</b>	
3 NAME OF DECEASED (Type or print) <b>FRIEDA A. FOX</b> First Middle Last		4 DATE OF DEATH Month <b>December</b> Day <b>13</b> Year <b>1967</b>	
5 SEX <b>Female</b>	6 COLOR OR RACE <b>White</b>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>July 21-1902</b>
9 AGE (in years last birthday) <b>65</b> yrs		10 IF UNDER 1 YEAR Months <b>65</b> Days <b>65</b> Hours <b>65</b> Min <b>65</b>	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b KIND OF BUSINESS OR INDUSTRY	
11 BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>		12 CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13 FATHER'S NAME <b>Richard F. Fox</b>		14 MOTHER'S MAIDEN NAME <b>Gretchen Struhs</b>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16 SOCIAL SECURITY NO	
17 INFORMANT <b>Mr. Lennox E. Fox, 1137 Carroll Street</b>		Address	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial infarction</b> DUE TO (b) <b>Arteriosclerosis - Coronary Arteries</b> DUE TO (c) <b>Chronic Coronary Arteriosclerosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m. <b>19</b>		20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e PLACE OF INJURY (Home, farm, factory, street office bldg., etc.)		20f (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>12/12</b> to <b>12/13</b> , 1967, that (I) (we) last saw the deceased alive on <b>12/13</b> , 1967, and that death occurred at <b>1137 Carroll Street</b> from causes and on the date stated above.			
22a SIGNATURE <b>Dr. John Shaw</b>		22b DATE SIGNED <b>12/13/67</b>	
22c PHYSICIAN'S NAME (Type) <b>Dr. John Shaw</b>		22d ADDRESS <b>5800 Edmondson Avenue</b>	
23a BURIAL, CREMATION, or other disposition (Specify) <b>BURIAL</b>		23b DATE THEREOF <b>12-15-1967</b>	
23c NAME OF CEMETERY OR CREMATORY <b>Stone Chapel Cemetery</b>		23d LOCATION (City or Town) (County) (State) <b>Pikesville, Maryland</b>	
24 FUNERAL DIRECTOR <b>Howard H. Hubbard, 4107 Wilkens Ave.</b>		25a REC'D BY REGISTRAR <b>21229</b>	
25b REGISTRAR'S SIGNATURE <b>DEC 15 1967</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
1651 CERTIFICATE OF DEATH 16509

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Cardinaltown, Md.</u> c. LENGTH OF STAY IN 1b <u>54 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Baltimore County General Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>✓</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Baltimore, Md.</u> d. STREET ADDRESS <u>4014 Hilton Rd. 21215</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>IDA FREEDLAND</u>		4. DATE OF DEATH Month Day Year <u>12-13 1967</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>9-8-84</u>
9. AGE (In years last birthday) <u>83 yrs.</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>	11. BIRTHPLACE (County & State, or foreign country) <u>LITHUANIA</u>
12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>		13. FATHER'S NAME <u>? RUDOLPH</u>	
14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>	
16. SOCIAL SECURITY NO. <u>XXXXXXXX</u>		17. INFORMANT <u>MRS. EVELYN FREEDLAND</u> Address <u>4725 THREE OAKS RD. #21208</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hangover, both legs</u> DUE TO <u>Arteriosclerotic peripheral Disease</u> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>10-20-67</u> to <u>12-13-67</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>12-13-67</u> , 19 <u>67</u> , and that death occurred at <u>2:30 PM</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Josue C. Laredo, M.D.</u>		22b. DATE SIGNED <u>12-13-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>JOSUE C. LAREDO, M.D.</u>		22d. ADDRESS <u>Baltimore Co. Gen. Hospital</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>12-14-67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>BNAI ISRAEL</u>	23d. LOCATION (City, town or county) (State) <u>BALTIMORE, MARYLAND</u>
24. FUNERAL DIRECTOR'S SIGNATURE <u>SOL KLEINSON &amp; BROS., 6010 REISTERSTOWN RD.</u>		25a. REC'D BY REGISTRAR <u>DEC 18 1967</u> 25b. REGISTRAR'S SIGNATURE <u>J. Charles Jones</u>	

TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of this certificate has been signed by the attending physician and completed by the funeral director. After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.





1  
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND 16515 CERTIFICATE OF DEATH 10510									
1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Timonium</b> c. LENGTH OF STAY IN 1b <b>years</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>102 Washington Street</b>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) e. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Timonium</b> d. STREET ADDRESS <b>102 Washington Street</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First <b>IRA</b> Middle <b>L.</b> Last <b>FREEMAN</b>					4. DATE OF DEATH Month <b>DEC.</b> Day <b>4</b> Year <b>1967</b>				
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>APRIL 28, 1918</b>		9. AGE (In years last birthday) <b>56</b> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Verifier</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Int. Mag. Service</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Henry H. Freeman, Sr.</b>					14. MOTHER'S MAIDEN NAME <b>Ida Herpel</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>NO</b>					16. SOCIAL SECURITY NO. <b>212-03-5440</b>		17. INFORMANT <b>Mrs. Evelyn C. Freeman, Same as # 2</b>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Infarction, Acute.</b> 4000 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) <b>Arteriosclerotic Heart Disease.</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					INTERVAL BETWEEN ONSET AND DEATH <b>Sudden</b>				
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <b>12-9-67</b> to <b>9-14-67</b> , that (I) <del>am</del> last saw the deceased alive on <b>9-14-67</b> , and that death occurred at <b>DOA</b> from the causes and on the date stated above.									
22a. SIGNATURE <b>Ruben S. Sebastian</b>					ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED		
22c. PHYSICIAN'S NAME (Type) <b>RUBEN S. SEBASTIAN</b>					22d. ADDRESS <b>2314 E. JOPPA ROAD, BALTO. MD.</b>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			23b. DATE THEREOF <b>Dec. 7, 1967</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Moreland Memorial Cemetery, Baltimore, Md.</b>		23d. LOCATION (City, town or county) (State)		
24. FUNERAL DIRECTOR <b>Wm. Cook-Brooks Towson, 1050 York Road Towson, Md. 21204</b>					25a. REC'D BY REGISTRAR <b>DEC 7 1967</b> 25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>				



**FOR STATE  
HEALTH DEPT**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1651

**MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

16511

1 DECEASED NAME (Type or Print) <b>JOSEPH HOWARD FRENCH</b>			2a DATE KNOWN OF ESTI- DEATH MATED <b>12-31 1967</b>			2b HOUR <b>8:25 PM</b>		
3 SEX <b>MALE</b>	4 RACE <b>WHITE</b>	5 DATE OF BIRTH <b>MAY 25 1911</b>	6 AGE (in years last birthday) <b>56 YRS</b>	7 UNDER 1 YEAR MONTHS DAYS	7 UNDER 24 HRS HOURS MIN	2c DATE PRONOUNCED DEAD Month <b>12</b> Day <b>31</b> Year <b>1967</b>		
7a BIRTHPLACE (State or foreign country) <b>BALTO MD</b>		7b CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>BALTIMORE</b>		
10 CITY OR TOWN OF DEATH <b>BALTO. Co.</b>		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>ST JOSEPH HOSP</b>		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>WESTERN ELECT.</b>		12b KIND OF BUSINESS OR INDUSTRY <b>RETIRED</b>		
13a USLA. RESIDENCE (Where deceased lived, if not institution Residence before admission) STATE <b>MARYLAND</b>		13b COUNTY <b>BALTIMORE</b>		13c CITY OR TOWN <b>BALTIMORE</b>		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER <b>4309 BELMAR AVE.</b>
14 FATHER'S NAME First <b>John</b> Middle <b>EARL</b> Last <b>FRENCH</b>			15 MOTHER'S MAIDEN NAME First <b>MARY</b> Middle <b>AGNES</b> Last <b>SELMA MYERS</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes no or unknown) <b>NO</b>		16b SOCIAL SECURITY NO <b>21216 1890</b>		17. INFORMANT <b>MARGARET HELEN FRENCH</b> ADDRESS <b>4309 BELMAR AVE</b>				
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last (b) <b>Atherosclerotic Heart</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Disease</b>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Sudden</b> <b>2+ yrs</b>
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b TIME OF INJURY Month, Day, Year HOUR A.M. P.M. <b>19</b>		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2 Item 18)				
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f LOCATION Street or R.F.D. No City or Town County State				
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>								
ACTUAL SIGNATURE <b>Charles F. O'Donnell</b>		EXAMINER'S NAME (Type) <b>Charles F. O'Donnell, M.D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22b DATE SIGNED <b>1/7/68</b>		
23a BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b DATE <b>1-1-68</b>		23c NAME OF CEMETERY OR CREMATORY <b>HOLY REDEEMER CEM</b>		23d LOCATION (City or Town) (County) (State) <b>BELAIR RD BALTO. MD.</b>		
24. FUNERAL DIRECTOR <b>THE DIPPEL BROTHERS INC 7110 BELAIR RD</b>				ADDRESS		25a REC'D BY REG STRAR <b>JAN 3 1968</b>		25b REGISTRAR'S SIGNATURE <b>Charles F. O'Donnell</b>



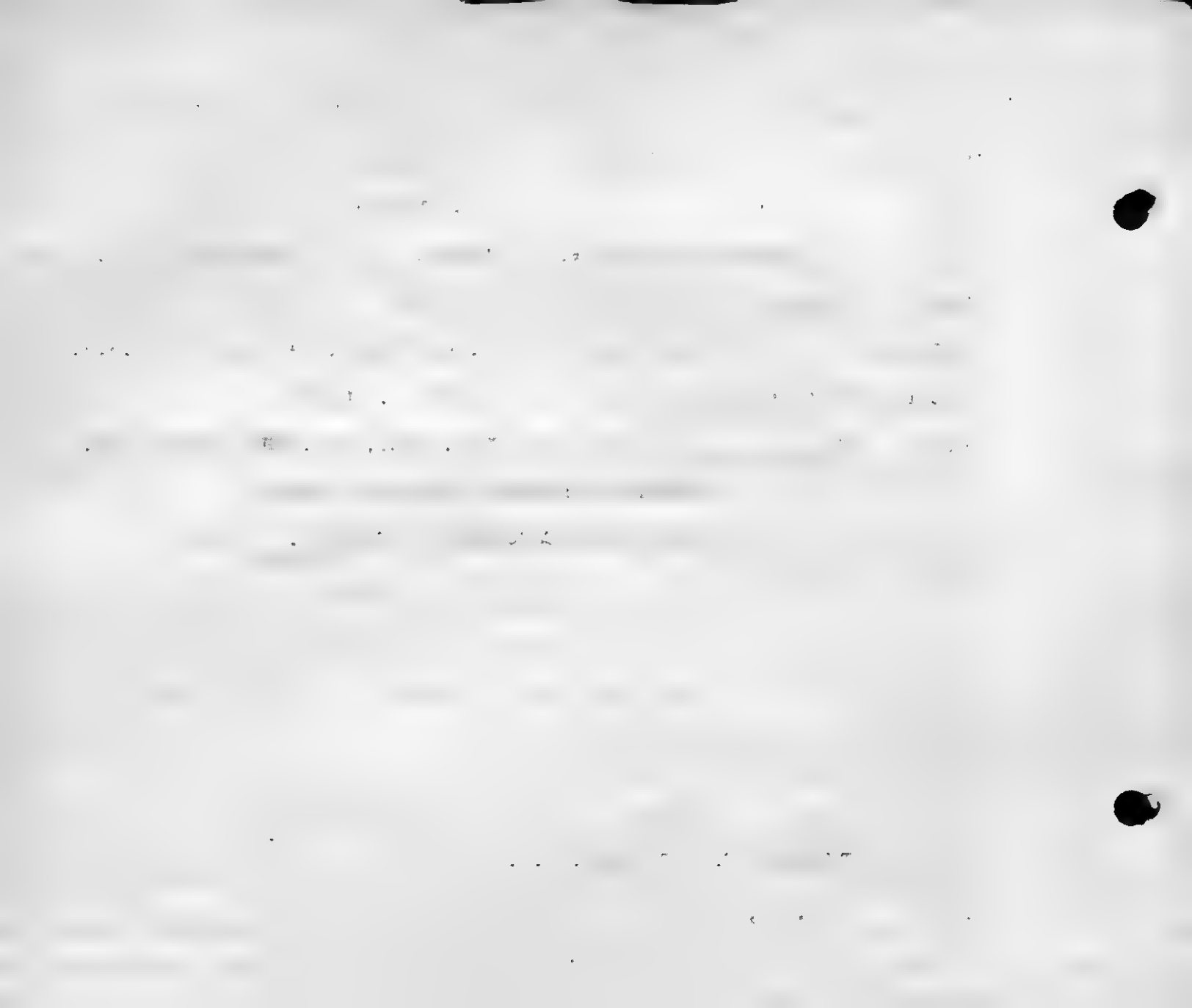
1  
FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any fee is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained to your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME  
5M 1/63

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH 16512											
1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> <b>MARYLAND</b>						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ANNE ARUNDEL</b> ✓ c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>ANNAPOLIS</b> d. STREET ADDRESS <b>15 RIVERVIEW</b>					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>FORT HOWARD</b>						c. LENGTH OF STAY IN Tb <b>46 DAYS</b>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>VETERANS ADMINISTRATION HOSPITAL</b>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <b>MUNFORD WILLIAM A. FRENCH</b>						4. DATE OF DEATH <b>DECEMBER 15, 19 67</b>					
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>10 25 07</b>		9. AGE (In years last birthday) <b>60</b> yrs.		IF UNDER 1 YEAR Months Days	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>MECHANIC</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Automobile</b>		11. BIRTHPLACE (State or foreign country) <b>W. ANNAPOLIS, MARYLAND</b>				12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>			
13. FATHER'S NAME <b>WILLIAM FRENCH COGGISHELL</b>						14. MOTHER'S MAIDEN NAME <b>EDITH M. MUNFORD</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>YES WW-11</b>						16. SOCIAL SECURITY NO. <b>214 05 0454</b>					
17. INFORMANT <b>CLIN. REC., VAH, FORT HOWARD, MD.</b>						Address					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											
PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <b>BLEEDING PULMONARY (OPERATIVE) ARTERY</b>											
Conditions, if any, which gave rise to immediate cause (b) <b>WIDE SPREAD CARCINOMA OF THE LUNG, WITH ABSCESS</b>											
(e), stating the underlying cause last. (c)											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a):											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <b>Theodore C. Patterson</b> M.D.						CHIEF MEDICAL EXAMINER <input type="checkbox"/>					
EXAMINER'S NAME (Type) <b>THEODORE C. PATTERSON, M.D.</b>						ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					
						DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					
						Address (Street, city, town, or county)					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>				22b. DATE THEREOF <b>Dec. 19, 1967</b>		22c. NAME OF CEMETERY OR CREMATORY <b>HILLCREST CEMETERY</b>				22d. LOCATION (City, town, or county) (State) <b>ANNAPOLIS, MARYLAND</b>	
23. FUNERAL DIRECTOR <b>Barclay E. Hopping</b>						24a. REC'D BY REGISTRAR <b>DEC 18 1967</b>					
ADDRESS <b>Hopping Funeral Home Annapolis, Maryland</b>						24b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
16521  
16513

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) e. STATE <b>md.</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Towson - Rural</b>				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Towson</b>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Greater Baltimore Medical Center</b>				d. STREET ADDRESS <b>104 Dublin Rd.</b>			
3. NAME OF DECEASED (Type or print) First <b>Mildred</b> Middle <b>Futch</b> Last <b>Futch</b>				4. DATE OF DEATH Month <b>12</b> Day <b>11</b> Year <b>19 67</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Dec. 27, 1908</b>	
9. AGE (in years last birthday) <b>58</b> yrs.		IF UNDER 1 YEAR Months <b>8</b> Days <b>11</b> Hours <b>19</b> Min.		IF UNDER 24 HRS. Months <b>8</b> Days <b>11</b> Hours <b>19</b> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>Baltimore</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>							
13. FATHER'S NAME <b>Edward B Hopkins</b>				14. MOTHER'S MAIDEN NAME <b>Olive Wilcock</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>No.</b>		17. INFORMANT <b>J.D. Futch</b>		Address <b>104 Dublin Rd., Towson, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of the Breast</b> <b>170x</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>DUE TO</b> (c) <b>DUE TO</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>12-10</b> , 19 <b>67</b> , to <b>12-11</b> , 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>12-11</b> , 19 <b>67</b> , and that death occurred at <b>9:45M</b> , from the causes and on the date stated above.							
22a. SIGNATURE <b>John E. Adams</b>				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <b>12/12/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>John E. Adams, M.D.</b>				22d. ADDRESS <b>6701 N. Charles Street</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>		23b. DATE THEREOF <b>12-14-67</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Greenmount</b>		23d. LOCATION (City, town or county) (State) <b>Baltimore, Md.</b>	
24. FUNERAL DIRECTOR <b>Wm. Cook-Brooks, Towson, Md.</b>				25a. REC'D BY REGISTRAR <b>DEC 19 1967</b>			
				25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>			





FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with the State Department of Health. 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (1)  
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16522

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

16514

1 PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Dundalk</b>		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <b>Dundalk</b>	
c. LENGTH OF STAY In Institution <b>14 years</b>		d. STREET ADDRESS <b>7322 Kirtley Road</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>7322 Kirtley Road</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First <b>Charles</b> Middle <b>W.</b> Last <b>Gabriszeski</b>		4 DATE OF DEATH Month <b>December</b> Day <b>16</b> Year <b>1967</b>	
5 SEX <b>Male</b>	6 COLOR OR RACE <b>White</b>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 AGE (In years last birthday) <b>48</b> yrs
9 USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Logistic Engineer</b>		10 KIND OF BUSINESS OR INDUSTRY <b>Westinghouse Corp.</b>	
11 BIRTHPLACE (State or foreign country) <b>Pennsylvania</b>		12 CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13 FATHER'S NAME <b>John Gabriszeski</b>		14 MOTHER'S MAIDEN NAME <b>Josephine Barkiewicz</b>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <b>Yes Army WWII</b>		16 SOCIAL SECURITY NO <b>187-05-7601</b>	
17 INFORMANT (Name) <b>Mrs. Rita Gabriszeski</b>		Address <b>Dundalk, Md. 7322 Kirtley Rd.</b>	
18 CAUSE OF DEATH (Enter only one cause per PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>420.1</b> DUE TO <b>Acute Coronary Occlusion</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>HCVD</b> DUE TO (c) <b>2 yrs</b>		INTERVAL BETWEEN ONSET AND DEATH <b>2 yrs</b>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month Day Year Hour <b>0</b> min <b>19</b> p.m.		20d INJURY DECLARED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)	
21 I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Theodore C. Patterson</b> M.D.		22. DATE SIGNED <b>12/16/67</b>	
EXAMINER'S NAME (Type) <b>Theodore C. Patterson M.D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> 105 Main Street ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> Dundalk, DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Md. 21222 Address (Street, city, town, or county)	
23a BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b DATE THEREOF <b>12/20/67</b>	23c NAME OF CEMETERY OR CREMATORY <b>Holy Cross Cemetery</b>	
24. FUNERAL DIRECTOR <b>John J. Duda, 7922 Wise Ave. Dundalk, Md.</b>		23d LOCATION (City or town) (County) (State) <b>Baltimore, Md.</b>	
25a REC'D BY REGISTRAR <b>DEC 20 1967</b>		25b REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

16523

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

16515

1 PLACE OF DEATH a COUNTY <b>Baltimore</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Towson</b>		c. LENGTH OF STAY IN 1b <b>03</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>1107 Hampton Garth</b>		d. STREET ADDRESS <b>1107 Hampton Garth</b>	
3 NAME OF DECEASED (Type or print) First Middle Last <b>MILDRED STONER GARMAN</b>		4. DATE OF DEATH Month Day Year <b>DECEMBER 3, 19 67</b>	
5. SEX <b>Female</b>	6 COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov. 30, 1898</b>
9 AGE (In years last birthday) yrs. <b>69</b>		IF UNDER 1 YEAR Months Days Hours Min	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Teacher</b>		10b KIND OF BUSINESS OR INDUSTRY <b>Retired</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Pennsylvania</b>		12 CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Arthur Stoner</b>		14. MOTHER'S MAIDEN NAME <b>Edna Weaver</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>Walter E. Garman, Sr. Same</b>	
17 INFORMANT Address <b>Walter E. Garman, Sr. Same</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>myocardial infarction</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)			
PART I. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Arteriosclerosis &amp; Diabetes</b>			
19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>1954</b> to <b>12-3-1967</b> , that (I) (we) last saw the deceased alive on <b>12-2-1967</b> , and that death occurred at <b>4 P.M.</b> from causes and on the date stated above.			
22a. SIGNATURE <b>Franklin E. Leslie</b>		22b. DATE SIGNED <b>12/4/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>Dr. Franklin Leslie</b>		22d. ADDRESS <b>302 E. 33rd. St. Baltimore</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>12-7-67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Evergreen</b>	23d. LOCATION (City or Town) (County) (State) <b>Gettysburg, Penna.</b>
24. FUNERAL DIRECTOR <b>Mitchell-Wiedefeld Home, Inc.</b> <b>6500 York Rd. Baltimore, Md. 21212</b>		25a. REC'D BY REGISTRAR DATE <b>DEC 7 1967</b>	25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>



16526

CERTIFICATE OF DEATH

16516

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY <u>Balto</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Baltimore</u> <u>Anne Arundel</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Balto</u>		c. LENGTH OF STAY IN 1b <u>87 yrs</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Caton Ridge Nursing Home</u>		d. STREET ADDRESS <u>Hance Ave 21640</u>	
3 NAME OF DECEASED (Type or print) <u>John S. Meiman</u>		4. DATE OF DEATH Month <u>12</u> Day <u>23</u> Year <u>1967</u>	
5 SEX <u>M</u>	6 COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 19-1980</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>unk</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>unk</u>	9. AGE (In years last birthday) <u>87 yrs</u>
11 BIRTHPLACE (County & State, or foreign country) <u>md</u>		12 CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13 FATHER'S NAME <u>John Meiman</u>		14. MOTHER'S MAIDEN NAME <u>unk</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>unk</u>		16. SOCIAL SECURITY NO <u>unk</u>	
17. INFORMANT <u>Nursing Home chart - Same</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebrovascular Thrombosis</u> DUE TO (b) <u>Arteriosclerosis</u> DUE TO (c) <u>unk</u>			INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs</u> <u>40 yrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>5/29</u> , 19 <u>67</u> , to <u>12/23</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>12/23</u> 19 <u>67</u> and that death occurred at <u>4:30 AM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>David E. Lickatoose</u>		22b. DATE SIGNED <u>12/23/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>David E. Lickatoose</u>		22d. ADDRESS <u>4 VFW Lane, Ellicott City, Md 21043</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>12/26/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Greenmount</u>	23d. LOCATION (City or Town) (County) (State) <u>Greenmount land Co</u>
24. FUNERAL DIRECTOR <u>Paul E. Schenck</u>		25a. REC'D BY REGISTRAR DATE <u>DEC 28 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Paul E. Schenck</u>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

16525

15517

1 PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Balto.</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>				c. LENGTH OF STAY IN 1b <b>6mths. 16dys.</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Spring Grove State Hospital</b>				e. STREET ADDRESS <b>9505 Ridgely Avenue</b>			
3 NAME OF DECEASED (Type or print) <b>Frederick John Geisberger</b>				4 DATE OF DEATH Month <b>December</b> Day <b>11</b> Year <b>1967</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>August 30, 1907</b>		9. AGE (In years last birthday) yrs <b>60</b>		IF UNDER: YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>William Geisberger</b>				14. MOTHER'S MAIDEN NAME <b>Margaret</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or both) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>220-03-7058</b>		17. INFORMANT <b>Records: Spring Grove State Hospital</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Carcinoma, origin undetermined, histo-</b> DUE TO <b>pathology unknown, proven at Johns Hopkins</b> (b) <b>Hospital in about 1965, with generalized</b> DUE TO <b>metastases</b> (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.							INTERVAL BETWEEN ONSET AND DEATH <b>2 years.</b>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Cellulitis with trophic ulcers 2 to lymphedema 2 to (a) above</b>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour <b>19</b> o.m. p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <del>(it)</del> (this hospital) attended the deceased from <b>May 31</b> , 1967, to <b>Dec. 11</b> , 1967, that (I) (we) last saw the deceased alive on <b>Dec. 11</b> , 1967, and that death occurred at <b>7:30 P.M.</b> , from causes and on the date stated above.							
22a. SIGNATURE <i>Anthony J. Young</i>				M.D. ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <b>12-12-67</b>	
22c. PHYSICIAN'S NAME (Type) <b>Anthony J. Young, M.D.</b>				22d. ADDRESS <b>Spring Grove State Hospital Baltimore, Maryland 21228</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>12/15/67</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National Cemeter.</b>		23d. LOCATION (City or Town) (County) (State) <b>Baltimore, Md.</b>	
24. FUNERAL DIRECTOR <b>Wm. J. Pickens Sons North</b>				25a. REC'D BY REGISTRAR <b>DEC 18 1967</b>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/765

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
16526					10518				
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)				
a. COUNTY <u>Baltimore</u> MARYLAND					a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>					c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Parkville</u>				
c. LENGTH OF STAY IN 1b <u>14</u>					d. STREET ADDRESS <u>3000 Lavender Avenue</u>				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Greater Baltimore Medical Center</u>					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)			First Middle Last			4. DATE OF DEATH		Month Day Year	
<u>MARY CATHERINE GESSWEIN</u>			<u>December</u>		<u>5</u>		<u>19</u>		<u>67</u>
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>7-10-1888</u>		9. AGE (In years last birthday) <u>79</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Housewife</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Baltimore, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>William Kelly</u>					14. MOTHER'S MAIDEN NAME <u>Carrie Stahle</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>			16. SOCIAL SECURITY NO. <u>220-32-3551</u>		17. INFORMANT <u>Forrest Gesswein</u>		Address <u>9514 Powderhorn Lane</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Renal Failure And Acute Myocardial Infarction</u> <u>7 + 01</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic Cardiovascular Disease</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____									INTERVAL BETWEEN ONSET AND DEATH _____
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (1) (this hospital) attended the deceased from <u>11/22</u> , 19 <u>67</u> , to <u>12/5</u> , 19 <u>67</u> , that (2) (we) last saw the deceased alive on <u>12/5/</u> 19 <u>67</u> , and that death occurred at <u>1:55M</u> , from the causes and on the date stated above.									
22a. SIGNATURE <u>John E. Adams</u>					ATTENDING PHYS. <input type="checkbox"/> M.D. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <u>12/5/67</u>		
22c. PHYSICIAN'S NAME (Type) <u>John E. Adams, M.D.</u>					22d. ADDRESS <u>Greater Baltimore Medical Center</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			23b. DATE THEREOF <u>12-9-1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Moreland Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Baltimore Co. Md.</u>		
24. FUNERAL DIRECTOR <u>La Salle Funeral Home</u>					ADDRESS <u>7401 Belair Road</u>		25a. REC'D BY REGISTRAR <u>DEC 11 1967</u>		
							25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

18519

16521

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a COUNTY <i>Baltimore</i> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Baltimore</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Garrison</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Towson</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Foxleight Nursing Home</i>		d. STREET ADDRESS <i>921 Southern Road</i>	
3 NAME OF DECEASED (Type or print) <i>Annie Gillett</i>		4 DATE OF DEATH Month <i>December</i> Day <i>27</i> Year <i>1967</i>	
5 SEX <i>Female</i>	6 COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>June 10, 1879</i>
9 AGE (In years (not birthday) yrs. <i>88</i> )		IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS. Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Fun Home</i>	11 BIRTHPLACE (County & State or foreign country) <i>England</i>
12 CITIZEN OF WHAT COUNTRY? <i>USA</i>		13. FATHER'S NAME <i>Thomas Parker</i>	
14. MOTHER'S MAIDEN NAME <i>Mlice Catherine Carter</i>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <i>No</i>	
16 SOCIAL SECURITY NO <i>None</i>		17 INFORMANT <i>Family records</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Senility</i> <i>443X</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <i>Hypertensive cardiovascular disease</i> DUE TO (c) <i></i>		INTERVAL BETWEEN ONSET AND DEATH <i>Years</i> <i>years</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <i>1964</i> to <i>12/27</i> , 19 <i>67</i> , that (I) (we) last saw the deceased alive on <i>12/27</i> , 19 <i>67</i> , and that death occurred at <i>7:55 PM</i> , from causes and on the date stated above			
22a. SIGNATURE <i>Dr. F. Cox</i>		22b. DATES SIGNED M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/> <i>12/27/67</i>	
22c. PHYSICIAN'S NAME (Type) <i>W. R. Cox 3rd</i>		22d. ADDRESS <i>1115 St Paul St., Balto., Md.</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	23b. DATE THEREOF <i>Dec. 30, 1967</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Bollin Green Cemetery</i>	23d. LOCATION (City or Town) (County) (State) <i>Camp Hill, Penna.</i>
24. FUNERAL DIRECTOR <i>John Burns' Sons, Towson, Maryland</i>		25a. REC'D BY REGISTRAR DATE <i>JAN 3 1968</i>	
		25b. REGISTRAR'S SIGNATURE <i>James J. J...</i>	



CERTIFICATE OF DEATH

16528

16520

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b> c. LENGTH OF STAY IN 1b <b>03/1</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>45 Delrey Ave.</b>		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b> d. STREET ADDRESS <b>45 Delrey Ave.</b> e. RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>George H. Willman, Jr.</b>		4. DATE OF DEATH Month <b>Dec.</b> Day <b>11</b> Year <b>1967</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>Cauc.</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>11/20/78</b>
9. AGE (In years last birthday) <b>89</b>		10. IF UNDER 1 YEAR Months <b>03</b> Days <b>11</b> Hours <b>00</b> Min <b>00</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>retired</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Howard M. Willman</b>		14. MOTHER'S MAIDEN NAME <b>Emily E. Magnes</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>213-03-2646 A</b>	
17. INFORMANT <b>Geo. H. Willman, Jr.</b>		18. ADDRESS <b>45 Delrey Ave.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <b>433.0</b> IMMEDIATE CAUSE (a) <b>Cardiac Arrest</b> DUE TO (b) <b>Arterio sclerotic Cardio Vascular</b> DUE TO (c) <b>Disease</b>		INTERVAL BETWEEN ONSET AND DEATH <b> sudden</b> <b>?</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>4/16</b> , 19 <b>59</b> , to <b>12/11</b> , 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>12/9</b> , 19 <b>67</b> , and that death occurred at <b>10 A.M.</b> from causes and on the date stated above			
22a. SIGNATURE <b>Joseph S. Blum</b>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <b>Joseph S. Blum</b>		22d. ADDRESS <b>1115 N. Calvert St.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>12/14/67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National Cem.</b>	23d. LOCATION (City or Town) (County) (State) <b>Baltimore, Md.</b>
24. FUNERAL DIRECTOR <b>Witzke F. D. - 4101 Edmudson Av.</b>		25a. REC'D BY REGISTRAR <b>DEC 14 1967</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)  
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
16521											
1. PLACE OF DEATH a. COUNTY <i>Baltimore</i> <i>Towson</i> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Towson</i> c. LENGTH OF STAY IN 1b <i>app. 14 days</i> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>Greater Balto Medical Center</i> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission) a. STATE <i>Md</i> b. COUNTY <i>Howard</i> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Ellicott City</i>					
3. NAME OF DECEASED (Type or print) <i>Robert Swings Glascock</i> First Middle Last 4. DATE OF DEATH <i>Dec. 22 19 67</i> Month Day Year						5. SEX <i>M</i> 6. COLOR OR RACE <i>CAU</i> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <i>10-19-23</i> 9. AGE (In years last birthday) <i>44</i> yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>C. &amp; P. Telephone Co.</i> 10b. KIND OF BUSINESS OR INDUSTRY <i>Tel. Co.</i> 11. BIRTHPLACE (County & State, or foreign country) <i>Maryland</i> 12. CITIZEN OF WHAT COUNTRY?						13. FATHER'S NAME <i>William E. Glascock</i> 14. MOTHER'S MAIDEN NAME <i>Day Margaret A. Day</i>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>yes</i> 16. SOCIAL SECURITY NO. <i>1942-1943 216-14-2603</i> 17. INFORMANT <i>Pt. Chert</i> Address						18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Pneumonia</i> 163X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) <i>Carcinoma of lung</i> DUE TO (c) <i>metastases to brain</i> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____ and that death occurred at _____ M, from the causes and on the date stated above.											
22a. SIGNATURE <i>[Signature]</i> 22c. PHYSICIAN'S NAME (Type) <i>E. LARRINAGE</i>						22b. DATE SIGNED <i>12-22/67</i> M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> 22d. ADDRESS <i>@ BHC</i>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i> 23b. DATE THEREOF <i>Dec 26, 1967</i> 23c. NAME OF CEMETERY OR CREMATORY <i>Balto. National Cemt.</i> 23d. LOCATION (City, town or county) (State) <i>Baltimore, Md.</i>						24. FUNERAL DIRECTOR ADDRESS <i>STERLING FUNERAL ESTATE 736 Edm. Av. Catonsville</i> 25a. RECEIVED BY REGISTRAR <i>DEC 27 1967</i> 25b. REGISTRAR'S SIGNATURE <i>[Signature]</i> DATE					





16530

CERTIFICATE OF DEATH

16522

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Owings Mills</b>		c. LENGTH OF STAY IN 1b <b>15 yrs.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Rosewood State Hospital</b>		e. STREET ADDRESS <b>Box 207</b>	
3. NAME OF DECEASED (Type or print) First <b>Sally</b> Middle <b>Ann</b> Last <b>GODEY</b>		4. DATE OF DEATH Month <b>12</b> Day <b>31</b> Year <b>19 67</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>7/26/43</b>
9. AGE (In years last birthday) <b>24</b> yrs		10. IF UNDER 1 YEAR Months <b>5</b> Days <b>1</b> Hours <b>19</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Dependent</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>none</b>	11. BIRTHPLACE (County & State or foreign country) <b>Washington, D.C.</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Thomas Rasin Godey</b>	
14. MOTHER'S MAIDEN NAME <b>Patricia Rose Frances Roseberry</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>	
16. SOCIAL SECURITY NO <b>none</b>		17. INFORMANT <b>Rosewood Records, Owings Mills, Maryland</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Necrotizing bronchial pneumonia</b> DUE TO (b) <b>491X</b> DUE TO (c) <b>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.</b>			INTERVAL BETWEEN ONSET AND DEATH <b>6 days</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Inst. Institutionalized, Mongolism, 15 yrs.</b>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)		20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that (a) (this hospital) attended the deceased from <b>1/10</b> , 19 <b>52</b> , to <b>12/31</b> , 19 <b>67</b> , that (b) (we) last saw the deceased alive on <b>12/31</b> , 19 <b>67</b> , and that death occurred at <b>11:00 p.m.</b> from causes and on the date stated above.	
22a. SIGNATURE <b>Richard A. Jones</b>		22b. DATE SIGNED <b>1/2/68</b>	
22c. PHYSICIAN'S NAME (Type) <b>Richard A. Jones, M.D.</b>		22d. ADDRESS <b>Rosewood St. Hosp., Owings Mills, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>1/5/68</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Rosewood Cemetery</b>	23d. LOCATION (City or Town) (County) (State) <b>Owings Mills, Md.</b>
24. FUNERAL DIRECTOR <b>J. F. Eline &amp; Sons</b>		25a. REC'D BY REGISTRAR <b>Reisters own, AL</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		DATE <b>JAN 9 1968</b>	



1653

## CERTIFICATE OF DEATH

16523

1. PLACE OF DEATH a. COUNTY <u>Baltimore - RANDALLSTOWN MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>_____</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RANDALLSTOWN</u>		c. LENGTH OF STAY IN 1b <u>32 days</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore, Md.</u>		d. STREET ADDRESS <u>3631 W. Belvedere Ave.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Baltimore County General Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Morris S. Goldman</u>		4. DATE OF DEATH <u>12-2-67</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6-7-67</u>
9. AGE (In years last birthday) <u>67</u> yrs		10. IF UNDER 1 YEAR Months <u>_____</u> Days <u>_____</u> Hours <u>_____</u> Min. <u>_____</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of work life. Even if retired) <u>Clauqueur</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Taxi Cab</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Russia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Israel Goldman</u>		14. MOTHER'S M maiden name <u>Sarah Goldman</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>216-07-6604A</u>	
17. INFORMANT <u>Mrs. Martin Goldman</u>		Address <u>3419 Jonell Dr</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Uremia</u> DUE TO (b) <u>Carcinoma of the v. t. with metastases.</u> -DUE TO (c) <u>metastases.</u>		INTERVAL BETWEEN ONSET AND DEATH <u>_____</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year <u>19</u> Hour a.m. <u>_____</u> p.m. <u>_____</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>11-1-67</u> , 19 <u>67</u> to <u>12-2</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>12-1-67</u> and that death occurred at <u>12:30 PM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Wenifredo N. Iglesia</u>		22b. DATE SIGNED <u>12-2-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>DR. WENIFREDO N. IGLESIA</u>		22d. ADDRESS <u>BALTIMORE COUNTY GENERAL HOSPITAL</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>12/3/67</u>	
23c. NAME OF CEMETERY OR CREMATOR <u>Providence Hill Baptist Church Assn. Balt. Md.</u>		23d. LOCATION (City or town) (County) (State) <u>Balt. Md.</u>	
24. FUNERAL DIRECTOR <u>Sal. Lewinson Bros.</u>		25a. REC'D BY REGISTRAR <u>_____</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		DATE <u>DEC 5 1967</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL. ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AIS  
ISM 7 62

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
16532  
CERTIFICATE OF DEATH  
1524

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Towson</b> c. LENGTH OF STAY IN <b>MD.</b> <b>yrs.</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>69 Burke Ave</b>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Towson</b> d. STREET ADDRESS <b>69 Burke Ave.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Lulu Todd Gore</b>				4. DATE OF DEATH <b>12-24-1967</b>			
5. SEX <b>F</b>		6. COLOR OR RACE <b>Cauc.</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Aug. 18, 1882</b>	
9. AGE (In years last birthday) <b>85</b> yrs.		IF UNDER 1 YEAR Months <b>7</b> Days <b>15</b>		IF UNDER 24 HRS. Hours <b>15</b> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY			
11. BIRTHPLACE (County & State, or foreign country) <b>Dorchester Co. Md.</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>Goldsmith Todd</b>				14. MOTHER'S MAIDEN NAME <b>Mary Jones</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>				16. SOCIAL SECURITY NO. <b>218-50-6263</b>			
17. INFORMANT <b>Elsie G. Gore</b>				Address <b>69 Burke Ave. Towson, Md. 21204</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>OCCLUSION OF CORONARY ARTERY</b> DUE TO <b>ARTERIOSCLEROSIS</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <b>7 weeks 15 yrs</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>NONE</b>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <b>NO</b>							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year <b>19</b> Hour a.m. <b>11</b> p.m. <b>40</b>							
20d. INJURY OCCURRED <input type="checkbox"/> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>							
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)							
20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from <b>Nov 4</b> 19 <b>67</b> to <b>Dec 24</b> 19 <b>67</b> , that (I) <del>was</del> last saw the deceased alive on <b>Dec 1</b> 19 <b>67</b> , and that death occurred at <b>11:40</b> M, from the causes and on the date stated above.							
22a. SIGNATURE <b>A.S. Choyant</b>							
22b. DATE SIGNED <b>Dec 24, 67</b>							
22c. PHYSICIAN'S NAME (Type) <b>Dr. A.S. Choyant</b>							
22d. ADDRESS <b>6210 YORK ROAD, BALTIMORE, MD 21244</b>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>12-27-1967</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Parkwood</b>		23d. LOCATION (City, town or county) (State) <b>Baltimore, Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Wm. Cook-Brooks Towson, Towson, Md.</b>							
25a. REC'D BY REGISTRAR <b>DEC 28 1967</b>							
25b. REGISTRAR'S SIGNATURE <b>Wm. Cook-Brooks</b>							



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (1)  
6M 1/67

1653

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10526

1 PLACE OF DEATH a COUNTY <u>BALTIMORE</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived if institution or residence before admission) a STATE <u>MARYLAND</u> b COUNTY <u>BALTO</u>	
b CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <u>Baltimore rural</u>		c LENGTH OF STAY IN TB <u>45 yrs</u>	
c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore - rural - over</u>		d STREET ADDRESS <u>10 East Elm Ave</u>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>10 East Elm Ave</u>		e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3 NAME OF DECEASED (Type or print) <u>PAUL TALBOT GOUSHA</u>		4 DATE OF DEATH Month <u>Dec</u> Day <u>22</u> Year <u>67</u>	
5 SEX <u>MALE</u>	6 COLOR OF RACE <u>White</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>13 Aug 1893</u>
9 AGE (in years last birthday) <u>74</u> yrs		10 UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min <u>  </u>	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Self employed</u>		10b KIND OF BUSINESS OR INDUSTRY <u>Electrician</u>	
11 BIRTHPLACE (State or foreign country) <u>Maryland</u>		12 CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13 FATHER'S NAME <u>Charles Gausa</u>		14 MOTHER'S MAIDEN NAME <u>Dena Hartman</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>Yes</u> <u>WW1</u>		16. SOCIAL SECURITY NO <u>None</u>	
17. INFORMANT <u>Mrs Emma Gousha 10 East Elm Avenue</u>		Address	
18 CAUSE OF DEATH (Enter on only one cause per line for (a), (b) and (c)) PART I DEATH WAS CAUSED BY <u>4221</u> IMMEDIATE CAUSE (a) <u>Atherosclerotic Cardiovascular Disease</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) <u>  </u> DUE TO (c) <u>  </u>		INTERVAL BETWEEN ONSET AND DEATH <u>Under</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Emphysema</u>		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. <u>  </u> p.m. <u>  </u> 19 <u>  </u>		20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)	
21 I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>John C. Hyle</u> M.D.		22. DATE SIGNED <u>12-22-67</u>	
EXAMINER'S NAME (Type) <u>JOHN C. Hyle</u>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) <u>7527 Belair Rd</u>	
23a BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	23b DATE THEREOF <u>12-27-1967</u>	23c NAME OF CEMETERY OR CREMATORY <u>Baltimore Nat'l Cemetery</u>	23d LOCATION (City or town) (County) (State) <u>Baltimore Co. Md.</u>
24 FUNERAL DIRECTOR <u>Lois John Funeral Home 7401 Belair Road</u>		25a RECEIVED BY REGISTRAR DATE <u>DEC 27 1967</u>	
25b REGISTRAR'S SIGNATURE <u>[Signature]</u>		25c REGISTRAR'S SIGNATURE <u>[Signature]</u>	





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201			
16534		16526	
1 PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE	
Baltimore MARYLAND		Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SPRING GROVE STATE HOSPITAL		d. STREET ADDRESS 419 West Gate Road	
3 NAME OF DECEASED (Type or print) Christine Alberta Grace		4. DATE OF DEATH December 5 19 67	
5 SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 14, 1907
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) stenographer		9. AGE (in years lost birthday) 60 yrs	
10b. KIND OF BUSINESS OR INDUSTRY		11 BIRTHPLACE (County & State, or foreign country) Maryland	
13 FATHER'S NAME		12 CITIZEN OF WHAT COUNTRY? U. S.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES (Yes, no, or unknown) (If yes give branch and service)		14. MOTHER'S MAIDEN NAME UNKNOWN (DECEASED)	
16. SOCIAL SECURITY NO. 216-18-3859		17. INFORMANT Records: SPRING GROVE STATE HOSPITAL	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 7037 Conditions, if any, which gave rise to immediate cause (b) stating the underlying cause (c) lost.		INTERVAL BETWEEN ONSET AND DEATH	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Fracture of ischium - three weeks		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF OTHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) Fall to the floor	
20c. TIME OF INJURY Month, Day, Year p.m. 11-22-67	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Spring Grove Hospital	
21. I certify that (this hospital) attended the deceased from Feb. 27, 19 59, to Dec. 5 19 67, that (we) last saw the deceased alive on Dec. 5 19 67, and that death occurred at M, from causes and on the date stated above.			
22a. SIGNATURE Edward F. Wilson		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) Edward F. Wilson, M.D.		22d. ADDRESS SPRING GROVE STATE HOSPITAL Baltimore, Maryland 21228	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF 12/7/67	23c. NAME OF CEMETERY OR CREMATORY LOUDON PARK CEM	23d. LOCATION (City or Town) (County) (State) BALTIMORE, MARYLAND
24. FUNERAL DIRECTOR WEBER FUNERAL HOME 5311 EDWARDS AVE.		25a. RECD BY REGISTRAR DEC 7 1967	25b. REGISTRAR'S SIGNATURE Nicholas Judge



CERTIFICATE OF DEATH

16535

16528

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>Maryland</u> ✓ b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fort Howard</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>Veterans Administration Hospital</u>		d. STREET ADDRESS <u>601 Collett Street 21217</u>	
3. NAME OF DECEASED (Type or print) First <u>HENRY</u> Middle <u>SIDNEY</u> Last <u>GREEN</u>		4. DATE OF DEATH Month <u>Dec.</u> Day <u>26</u> Year <u>19 67</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 4, 1901</u>
9. AGE (In years last birthday) yrs. <u>66</u>		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>	IF UNDER 24 HRS Hours <u>  </u> Min. <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Porter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Race Track</u>	11. BIRTHPLACE (County & State, or foreign country) <u>Baltimore, Maryland</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Thomas Green</u>	
14. MOTHER'S MAIDEN NAME <u>Matilda Brooks</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>Yes</u> <u>WW-11</u>	
16. SOCIAL SECURITY NO. <u>218 07 53 48</u>		17. INFORMANT <u>Clinical Rcds, VA Hospital, Fort Howard, Md</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>MYOCARDIAL INFARCTION</u> <u>1201</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) <u>ARTERIOSCLEROTIC CORONARY THROMBOSIS</u> DUE TO (c) <u>  </u>		INTERVAL BETWEEN ONSET AND DEATH <u>  </u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>CEREBRAL ARTERIOSCLEROSIS WITH MULTIPLE THROMBOSES AND HEMIPARESIS,</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <u>BILATERAL.</u>	
20c. TIME OF INJURY Month, Day, Year Hour <u>  </u> o.m. <u>  </u> p.m. <u>  </u> 19 <u>  </u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>  </u>	20f. (City or town) (County) (State) <u>  </u>
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>Aug. 29, 19 67</u> to <u>Dec. 26, 19 67</u> that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>Dec. 26, 19 67</u> , and that death occurred at <u>11:30</u> from causes and on the date stated above			
22a. SIGNATURE <u>John D. Talbert</u>		22b. DATE SIGNED <u>12/27/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>JOHN D. TALBERT, M.D.</u>		22d. ADDRESS <u>VA Hospital, Fort Howard, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>12-30-67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Arbutus Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Arbutus, Maryland</u>
24. FUNERAL DIRECTOR <u>GEORGE KELSON FUNERAL HOME</u>		25a. REC'D BY REGISTRAR <u>1348 N Calhoun St. Balto. Md.</u>	
25b. REGISTRAR'S SIGNATURE <u>DEC 27 1967</u>		25c. REGISTRAR'S SIGNATURE <u>  </u>	



## CERTIFICATE OF DEATH

16536

16529

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2, and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glen Arm</u>		c. LENGTH OF STAY IN 1b <u>14 yrs</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Villa Maria, Notch Cliff</u>		d. STREET ADDRESS <u>Glen Arm Rd.</u>	
3. NAME OF DECEASED (Type or print) <u>Sp. Mary Laurina Greenfeld</u>		4. DATE OF DEATH <u>12</u> Month <u>9</u> Year <u>1967</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-12-1879</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Teacher</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <u>Hudson City New Jersey</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Herman Greenfeld</u>		14. MOTHER'S MAIDEN NAME <u>Frances Kumber</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>220-54-3000</u>	
17. INFORMANT <u>Dr. M. Kathleen</u>		Address <u>Glen Arm Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Arteriosclerosis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>August</u> , 19 <u>66</u> , to <u>November</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>29th</u> 19 <u>67</u> , and that death occurred at <u>2:15</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>Henry McCorkle</u>		22b. DATE SIGNED <u>12-13-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Henry McCorkle MD</u>		22d. ADDRESS <u>Phoenix, Md 21131</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>Dec 12, 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>SISTERS CEMETERY</u>	23d. LOCATION (City or Town) (County) (State) <u>GLEN ARM MARYLAND</u>
24. FUNERAL DIRECTOR <u>Raymond J. Curran</u>		25. REGISTRATION DATE <u>DEC 26 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Francis Judge</u>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH			
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201			
CERTIFICATE OF DEATH			
1 PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Randalltown</u>	c. LENGTH OF STAY IN it <u>1 mo</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rur 1 Randallstown</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>10120 Steelway Road</u>		d. STREET ADDRESS <u>10916 Steelway Road</u>	
3 NAME OF DECEASED (Type or print) <u>Albert A. Gries</u>		4 DATE OF DEATH Month <u>December</u> Day <u>4</u> Year <u>1967</u>	
5 SEX <u>Male</u>	6 COLOR OR RACE <u>White</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>Dec. 29, 1908</u> 55 yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Contractor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Building</u>	9. AGE (In years last birthday) IF UNDER 1 YEAR: Months <u>4</u> Days <u>19</u> Hours <u>57</u>
11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Arnold J. Gries</u>		14. MOTHER'S MAIDEN NAME <u>Mary Triplett</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO <u>-----</u>	
17. INFORMANT <u>Mrs. Frances Gries</u>		Address <u>Randallstown Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> DUE TO (b) <u>Chronic Coronary insuff.</u> DUE TO (c) <u>HASCVD</u>			INTERVAL BETWEEN ONSET AND DEATH
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour <u>a.m.</u> <u>19</u> p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>April</u> , 19 <u>63</u> to <u>Dec 1</u> , 19 <u>67</u> , that (II) (we) last saw the deceased alive on <u>Dec 1</u> , 19 <u>67</u> , and that death occurred at <u>4:02 PM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>John J. Darrell</u>		22b. DATE SIGNED <u>12-5-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>J. Darrell</u>		22d. ADDRESS <u>9017 Liberty Rd Randallstown</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>12-7-67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Louis Chapel Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Baltimore</u>
24. FUNERAL DIRECTOR <u>Harry W. Hight</u>		25a. REC'D BY REGISTRAR <u>DEC 11 1967</u>	
ADDRESS <u>Sykesville, Md.</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 2 hours after death.

VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

16538

16531

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b>		c. LENGTH OF STAY IN 1b <b>30 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Veterans Administration Hospital</b>				d. STREET ADDRESS <b>1117 Harlem Avenue</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>LEONARD</b> Middle ----- Last <b>GRIFFIN</b>				4. DATE OF DEATH Month <b>Dec.</b> Day <b>28</b> Year <b>19 67</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>4/5/89</b>	9. AGE (In years last birthday) yrs. <b>78</b>	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Butcher</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Meat House</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Baltimore, Md.</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>	
13. FATHER'S NAME <b>Samuel Griffin</b>				14. MOTHER'S MAIDEN NAME <b>Mamie Griffin</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>Yes WW-1</b>		16. SOCIAL SECURITY NO <b>214 03 11 96</b>		17. INFORMANT <b>Clinical Rcds, VA Hospital, Fort Howard Md</b> Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>INFARCTION OF MYOCARDIUM</b> DUE TO (b) <b>ARTERIOSCLEROTIC HEART DISEASE</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c)							INTERVAL BETWEEN ONSET AND DEATH <b>Recent</b>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>ABSCESS, RIGHT LUNG</b>							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)		20f. (City or town) (County) (State)	
21. I certify that (1) <input checked="" type="checkbox"/> this hospital attended the deceased from <b>Nov. 28</b> , 19 <b>67</b> to <b>Dec. 28</b> , 19 <b>67</b> , that (2) <input checked="" type="checkbox"/> we lost saw the deceased alive on <b>Dec. 28</b> , 19 <b>67</b> , and that death occurred at <b>9:20</b> P.M., from causes and on the date stated above							
22a. SIGNATURE <b>J. D. Talbert</b>				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>12/29/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>J. D. TALBERT, M.D.</b>				22d. ADDRESS <b>VA Hospital, Fort Howard, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>1-2-68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National</b>		23d. LOCATION (City or Town) (County) (State) <b>Baltimore, Maryland</b>	
24. FUNERAL DIRECTOR <b>ELROY WILSON FUNERAL HOME</b>				25a. REC'D BY REGISTRAR <b>Elroy Wilson</b> DATE <b>JAN 2 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME 15  
6M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16531

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

16532

1 PLACE OF DEATH a COUNTY <b>Baltimore</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a STATE <b>Maryland</b> b COUNTY <b>Calvert</b>	
b CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town) <b>Owings Mills</b>		c CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town) <b>Prince Frederick</b>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Rosewood State Hospital</b>		e STREET ADDRESS <b>-</b>	
3. NAME OF DECEASED (Type or print) First <b>Vera</b> Middle <b>Bernice</b> Last <b>GRIFFITH</b>		4 DATE OF DEATH Month <b>12</b> Day <b>6</b> Year <b>19 67</b>	
5. SEX <b>Female</b>	6 COLOR OR RACE <b>White</b>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>10-23-21</b>
9 AGE (In years last birthday) <b>46</b> yrs		IF UNDER 1 YEAR Months <b>12</b> Days <b>6</b> Hours <b>19</b> Min <b>67</b>	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Dependent</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>none</b>	
11. BIRTHPLACE (State or foreign country) <b>Calvert Co., Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Robert Carl Griffith (D)</b>		14 MOTHER'S MAIDEN NAME <b>Hattie Louise Brooks (D)</b>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16 SOCIAL SECURITY NO <b>none</b>	
17 INFORMANT <b>Rosewood Records, Owings Mills, Maryland</b>		Address	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Atelectasis and Pneumonia, Right</b> DUE TO <b>Empyema, Right</b> CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last <b>Pulmonary Laceration, Superficial</b> DUE TO <b>Fracture ribs 4,5,&amp;6 Right</b> estimated <b>7-10 days</b>		INTERVAL BETWEEN ONSET AND DEATH <b>7-10 days</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Mental Retardation due to traumatic encephalopathy</b>		19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <b>unfamiliar</b>	
20c TIME OF INJURY Month, Day Year Hour a.m. <b>unfamiliar</b> p.m. <b>unfamiliar</b>		20d INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work	
20e PLACE OF INJURY (Home, farm, factory, street, office, playground, etc.) <b>Rosewood</b>		20f (City or town) (County) (State) <b>Owings Mills - Balt. Md.</b>	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>D. D. Caples</b> M.D.		22. DATE SIGNED <b>12/6/67</b>	
EXAMINER'S NAME (Type) <b>D. D. Caples, M.D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
23a BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b DATE THEREOF <b>12-9-67</b>	
23c NAME OF CEMETERY OR CREMATORY <b>Mt. Harmony Ch. Cem.</b>		23d LOCATION (City or town) (County) (State) <b>Owings Calvert Md.</b>	
24. FUNERAL DIRECTOR <b>Hutchins Funeral Home Owings, Md.</b>		25a REC'D BY REGISTRAR <b>DEC 12 1967</b>	
ADDRESS		25b REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>	



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 1-AM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

**FOR STATE HEALTH DEPT.**

16540

**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

16533

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>BALTIMORE</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rockton Parkville</b>			c. LENGTH OF STAY IN 1b			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore 21234</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>1705 Taylor Avenue</b>				d. STREET ADDRESS <b>1705 Taylor Avenue</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>DONALD</b> Middle <b>MICHAEL</b> Last <b>GRIM</b>				4. DATE OF DEATH <b>December 28, 1967</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 27, 1967.</b>		9. AGE (In years, last birthday) yrs <b>5</b>		IF UNDER 1 YEAR Months <b>1</b> Days <b>1</b> Hours <b></b> Min <b></b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Thomas S. Grim</b>				14. MOTHER'S MAIDEN NAME <b>Reeda Haman</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO <b>None</b>		17. INFORMANT <b>Mr. Thomas S. Grim</b>		Address <b>(Same)</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Interstitial pneumonia (SDI)</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Early bronchopneumonia (SDII)</b> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day Year Hour a.m. <b>19</b> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , inspect an <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from <b>Natural causes</b> <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>Charles S. Springate</b> M.D.				22. DATE SIGNED <b>December 28, 1967</b>			
EXAMINER'S NAME (Type) <b>Charles S. Springate, M.D.</b>				Address (Street, city, town, or county)			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>12/30/67.</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Moreland Memorial Cemetery</b>		23d. LOCATION (City or town) (County) (State) <b>Baltimore, Md.</b>	
24. FUNERAL DIRECTOR <b>Leonard J. Ruck, Inc. Balto. Md. 21214</b>				25a. REC'D BY REG. STRAR DATE <b>JAN 2 1968</b>		25b. REG. STRAR'S SIGNATURE	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

<div style="display: flex; justify-content: space-between;"> <span>16541</span> <span>DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201</span> <span>16534</span> </div> <h2 style="text-align: center;">CERTIFICATE OF DEATH</h2>											
1. PLACE OF DEATH a. COUNTY <b>Baltimore County</b> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Parkville</b>				c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Parkville</b>					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>2933 Willoughby Road</b>						d. STREET ADDRESS <b>2933 Willoughby Road</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Ellen Brady Groves</b>						4. DATE OF DEATH Month <b>12</b> Day <b>17</b> Year <b>1967</b>					
5. SEX <b>f</b>		6. COLOR OR RACE <b>w</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>10/1/1882</b>		9. AGE (In years last birthday) <b>85</b> yrs		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>at home</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>			12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		
13. FATHER'S NAME <b>unknown Brady</b>						14. MOTHER'S MAIDEN NAME <b>unknown</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT <b>daughter</b> Address <b>2933 Willoughby Rd.</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerosis - Hypertensive</b> DUE TO <b>C.V. Disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c)											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>10/1/67</b> to <b>12/17/67</b> , that (I) (we) last saw the deceased alive on <b>12/17/67</b> , and that death occurred at <b>9:15 P.M.</b> from causes and on the date stated above											
22a. SIGNATURE <b>Nathan Janney</b> M.D.						ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED <b>12/18/67</b>			
22c. PHYSICIAN'S NAME (Type) <b>Dr. Nathan Janney</b>						22d. ADDRESS <b>7101 Harford Road</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		23b. DATE THEREOF <b>12/21/67</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Parkwood</b>				23d. LOCATION (City or Town) (County) (State) <b>Parkville, Ba. Co., Md.</b>			
24. FUNERAL DIRECTOR <b>CHAS. F. EVANS &amp; SON</b>						ADDRESS <b>8802 Harford Road</b>		25a. REC'D BY REGISTRAR <b>DEC 22 1967</b>		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>	





# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

16542

16535

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived f institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>BALTIMORE</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Towson</b>		c. LENGTH OF STAY in lb <b>Riderwood</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>St. Joseph Hospital</b>		d. STREET ADDRESS <b>7906 Roldrew Avenue</b>	
3. NAME OF DECEASED (Type or print) First <b>CONSTANCE</b> Middle <b>C</b> Last <b>GUNTHER</b>		4. DATE OF DEATH Month <b>December</b> Day <b>21</b> Year <b>1967</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>June 19, 1920</b>
9. AGE (In years lost birthday) <b>47</b> yrs		10. F UNDER 1 YEAR Months <b>4</b> Days <b>19</b> Hours <b>21</b> Min <b>67</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Clerk</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>California</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Leroy P. Collins</b>		14. MOTHER'S MAIDEN NAME <b>Constance J. Jones</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO	
17. INFORMANT <b>Wm. E. Gunther</b>		Address <b>Cockeysville, Md.</b>	
18. CAUSE OF DEATH (Enter on only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Multiple traumatic injuries</b> DUE TO (b) <b>8164</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Acute ethylism</b>			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18) <b>Driver in auto-auto collision</b>	
20c. TIME OF INJURY Hour <b>9:06</b> p.m. Month <b>12-21</b> Year <b>1967</b>	20d. INJURY OCCURRED Where <input type="checkbox"/> at work <input checked="" type="checkbox"/> Not Where <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) <b>street</b>	20f. (City or town) <b>Towson</b> (County) <b>Baltimore</b> (State) <b>Md.</b>
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Charles S. Springate</b>		22. DATE SIGNED <b>December 22, 1967</b>	
EXAMINER'S NAME (Type) <b>Charles S. Springate, M.D.</b>		DEPUTY MEDICAL EXAMINER <input type="checkbox"/> Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>12/23/1967</b>	23c. NAME OF CEMETERY OR CREMATORY <b>St. Luke's Cemetery</b>	23d. LOCATION (City or Town) (County) (State) <b>Fine Creek Mills, Va.</b>
24. FUNERAL DIRECTOR <b>Mitchell-Wiedefeld Home 6500 York Rd Towson, Md.</b>		25a. REC'D BY REGISTRAR <b>DEC 29 1967</b>	
25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>			



CERTIFICATE OF DEATH

16543

10536

1 PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>B. Co.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>		c. LENGTH OF STAY IN TB <u>12-15-67-12-20 3229 Dundalk Ave-DUNDALK MD</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Greater Baltimore Medical Center</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3 NAME OF DECEASED (Type or print) <u>William Howard Hackett</u>		4 DATE OF DEATH Month <u>Dec.</u> Day <u>20</u> Year <u>1967</u>	
5 SEX <u>Male</u>	6 COLOR OR RACE <u>cau</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4-15-98</u>
9. AGE (in years, lost birthday) yrs. <u>69</u>		10. IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>ACCOUNTANT</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>captn Retired</u>	
11 BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12 CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13 FATHER'S NAME <u>James Hackett (DEC)</u>		14 MOTHER'S MAIDEN NAME <u>MARGARET BARTHEL</u> <u>unk at time of Adm.</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>216-10-9880</u>	
17. INFORMANT <u>MARY E. HACKETT 3779 DUNDALK AV</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Thrombosis right middle cerebral artery</u> DUE TO (b) <u>  </u> DUE TO (c) <u>  </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>			
19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. <u>  </u> p.m. <u>19</u>	20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>Dec. 15th</u> , 1967, to <u>Dec. 20th</u> , 1967, that (I) (we) last saw the deceased alive on <u>Dec. 20th</u> , 1967, and that death occurred at <u>4:10 P.M.</u> , from causes and on the date stated above.			
22a SIGNATURE <u>Dr. Gabrielle Marie Gregor</u>		22b DATE SIGNED <u>Dec 20th 1967</u>	
22c PHYSICIAN'S NAME (Type) <u>GABRIELLE MARIE GREGOR</u>		22d ADDRESS <u>6701 21st. Charles St.</u>	
23a BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b DATE THEREOF <u>12/23/67</u>	23c NAME OF CEMETERY OR CREMATORY <u>OAK LAWN</u>	23d LOCATION (City or Town) (County) (State) <u>COLGATE MD</u>
24 FUNERAL DIRECTOR <u>ULLRICH FUNERAL HOME - DUNDALK MD</u>		25a REC'D BY REGISTRAR DATE <u>DEC 26 1967</u>	
25b REGISTRAR'S SIGNATURE <u>Charles J. Jorgensen</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



16544

## CERTIFICATE OF DEATH

16537

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Handallstown</b>		c. LENGTH OF STAY IN 1b <b>29 days</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CATONSVILLE</b>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Baltimore Co. Gen. Hosp.</b>			d. STREET ADDRESS <b>5454 Addington Road</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3 NAME OF DECEASED (Type or print) <b>Frances B. Hall</b>			4 DATE OF DEATH Month <b>12.</b> Day <b>27</b> Year <b>1967</b>		
5 SEX <b>Female</b>	6 CO. OR OR RACE <b>White</b>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>12/18/78</b> <b>89</b>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>	11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>John A. Graves</b>			14. MOTHER'S MAIDEN NAME <b>Mary Owens</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO.	17. INFORMANT Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <b>Broncho-pneumonia</b> 4040 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Fracture Hip, Left</b> DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <b>Fell at home</b>			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>Nov 9 1967</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Nov. 28, 1967</b> , to <b>Dec. 27, 1967</b> , that (I) (we) last saw the deceased alive on <b>12-27-1967</b> , and that death occurred at <b>11:30 AM</b> , from causes and on the date stated above.					
22a. SIGNATURE <b>Jose C. Laredo M.D.</b>		22b. DATE SIGNED <b>12-27-67</b>		22c. PHYSICIAN'S NAME (Type) <b>M.D.</b>	
22d. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>12/30/67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Holy Cross</b>		23d. LOCATION (City or Town) (County) (State) <b>Anne Arundel Co. Md.</b>	
24. FUNERAL DIRECTOR <b>McCully Funeral Home</b>		ADDRESS <b>237 Patapsco Ave.</b>		25a. REC'D BY REGISTRAR DATE <b>JAN 2 1968</b>	
25b. REGISTRAR'S SIGNATURE					



## CERTIFICATE OF DEATH

16538

16545

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a COUNTY <u>Balto.</u> MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) b STATE <u>MD</u> b COUNTY <u>Balto.</u>			
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>1521 St</u>		c LENGTH OF STAY in lb <u>Life</u>		c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Balto. - 28</u>			
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Caton Ridge Nursing Home</u>				d STREET ADDRESS <u>125 Winters Lane</u>		e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Helen A. Hall</u>				4 DATE OF DEATH Month <u>12</u> Day <u>11</u> Year <u>19 67</u>			
5 SEX <u>F</u>	6 COLOR OR RACE <u>N</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <u>3-30-07</u>		9 AGE (In years last birthday) <u>60</u> yrs.	IF UNDER 1 YEAR Months <u>12</u> Days <u>11</u> Hours <u>19</u> Min <u>67</u>	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Home</u>		10b KIND OF BUSINESS OR INDUSTRY <u></u>		11 BIRTHPLACE (County & State, or foreign country) <u>MD</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13. FATHER'S NAME <u>Daniel Harri-day</u>				14. MOTHER'S MAIDEN NAME <u>Jennie W. Hiam</u>			
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16 SOCIAL SECURITY NO <u></u>		17 INFORMANT <u>Nursing Home Chart</u> Address <u></u>			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebrovascular Thrombosis</u> DUE TO (b) <u>Arteriosclerosis</u> DUE TO (c) <u></u>							INTERVAL BETWEEN ONSET AND DEATH <u>20 yrs</u>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Prior Strokes</u>							19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1B.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u></u>		20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>7/1</u> , 19 <u>67</u> , to <u>12/11</u> , 19 <u>67</u> that (I) (we) lost saw the deceased alive on <u>12/11</u> 19 <u>67</u> and that death occurred at <u>2:20 AM</u> , from causes and on the date stated above.							
22a. SIGNATURE <u>David E. Zickel</u> M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>12/11/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>David E. Zickel</u>				22d. ADDRESS <u>4 VFW Home, Ellicott City, Md</u>			
23a BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>12-15-1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Arbutus Mem. Park</u>		23d. LOCATION (City or Town) (County) (State) <u>Baltimore, Maryland</u>	
24. FUNERAL DIRECTOR <u>Arlington S. Phillips 1727 N. Monroe Street</u>				25a REC'D BY REGISTRAR <u>DEC 15 1967</u>		25b REGISTRAR'S SIGNATURE <u>Charles Judge</u>	





1  
TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1  
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
16546  
16539  
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Baltimore		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rodgers Forge		c. LENGTH OF STAY IN 1b	
2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland		b. COUNTY Baltimore		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rodgers Forge - 21212	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 249 A Rodgers Forge Rd.-21212		d. STREET ADDRESS 249 A Rodgers Forge Rd.		e. IS RESIDENCE ON A FARM YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) WILLIAM		First Middle Last BERTRAM HANAUER, Jr.		4. DATE OF DEATH December 8, 1967	
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH July 11, 1892		9. AGE (In years last birthday) 75 yrs.		10. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PROGRAM DIRECTOR RADIO STATION, RETIRED		10b. KIND OF BUSINESS OR INDUSTRY BALTIMORE MARYLAND		11. BIRTHPLACE (County & State or foreign country) U.S.A.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME William Bertram Hanauer		14. MOTHER'S MAIDEN NAME Emma M. Seidler	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) Yes World War I		16. SOCIAL SECURITY NO. 212-09-2751A		17. INFORMANT Mrs. Beth T. Hanauer-249 A Rodgers Forge Rd.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) DUE TO Coronary Insufficiency Arteriosclerotic H. D. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO Rheumatic H. D. Embolism PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II. of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)		INTERVAL BETWEEN ONSET AND DEATH 20 yrs.		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21. I certify that (I) (this hospital) attended the deceased from 1950 to 12/8, 1967, that (I) (we) last saw the deceased alive on 11/15, 1967, and that death occurred at 11 AM, from the causes and on the date stated above		22a. SIGNATURE C. Edward Leach		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) C. EDWARD LEACH		22d. ADDRESS 14 E. Eager St. - 12-9-67		22e. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation Dec. 9, 1967		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY Greenmount Crematory	
23d. LOCATION (City, town or county) Baltimore, Maryland		23e. STATE Maryland		23f. COUNTY Baltimore	
24. FUNERAL DIRECTOR'S SIGNATURE H. Sander & Sons, Inc. Balto., Md.		24a. ADDRESS		24b. REC'D BY REGISTRAR DATE DEC 12 1967	
24c. REGISTRAR'S SIGNATURE Charles Judge		24d. DATE		24e. REGISTRAR'S SIGNATURE	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

1654

10540

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Towson</b> c. LENGTH OF STAY IN 1b <b>18 days</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Greater Baltimore Medical Center</b>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Baltimore, Maryland</b> d. STREET ADDRESS <b>2728 Miles Ave</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First: <b>Marie</b> Middle: <b>S. Harrington</b> Last: <b></b>				4. DATE OF DEATH Month: <b>12</b> Day: <b>3</b> Year: <b>1967</b>			
5. SEX <b>F</b>		6. COLOR OR RACE <b>W</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>4-3-12</b>	
9. AGE (in years last birthday) <b>55 yrs.</b>		IF UNDER 1 YEAR Months: <b></b> Days: <b></b>		IF UNDER 24 HRS. Hours: <b></b> Min.: <b></b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b></b>		11. BIRTHPLACE (County & State, or foreign country) <b>Virginia</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>							
13. FATHER'S NAME <b>Henry L. Looker</b>				14. MOTHER'S MAIDEN NAME <b>Rogers, Nannie S.</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <b>NA</b>				16. SOCIAL SECURITY NO. <b>579-07-5829</b>		17. INFORMANT <b>GBMC Admission Sheet</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of the bladder c multiple</b> <b>Pulmonary + bony metastasis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) <b></b> DUE TO (c) <b></b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b></b>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m. <b></b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>11-15, 1962</b> to <b>12-3, 1962</b> , that (I) (we) last saw the deceased alive on <b>12-3, 1962</b> , and that death occurred at <b>5:45 AM</b> , from the causes and on the date stated above.							
22a. SIGNATURE <b>DURGADAS KULKARNI</b>				22b. DATE SIGNED <b>12-3-67</b>			
22c. PHYSICIAN'S NAME (Type) <b>DURGADAS KULKARNI</b>				22d. ADDRESS <b>GBMC Balto 4 MD.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>12/5/1967</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Holly Hill Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Baltimore, Md.</b>	
24. FUNERAL DIRECTOR <b>Eugenia K. Seitz 5209 York Rd.</b> <b>Seitz Funeral Home Balto. Md. 21212</b>				25a. REC'D BY REGISTRAR <b>DEC 5 1967</b> 25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

MEDICAL CERTIFICATION



# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute a separate certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Owings Mills</b> c. LENGTH OF STAY IN 1b <b>2 months</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>11009 Reisterstown Road</b>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Owings Mills</b> d. STREET ADDRESS <b>11009 Reisterstown Road</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <b>Theodore Earl Harris</b>			4. DATE OF DEATH Month <b>December</b> Day <b>16</b> Year <b>1967</b>						
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>May 31, 1890</b>		9. AGE (In years last birthday) <b>77</b> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Railroad Worker</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Pennsylvania R.R. Baltimore Co., Md.</b>			11. BIRTHPLACE (State or foreign country) <b>U.S.A.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Harris</b>					14. MOTHER'S MAIDEN NAME <b>Troyer</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>			16. SOCIAL SECURITY NO. <b>716-01-8358</b>		17. INFORMANT Address <b>Mrs. Ruth Showalter 1314 Nelson St. Richmond, Va.</b>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> <b>260x</b> DUE TO <b>Hypertensive Arteriosclerotic C-V Disease</b> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) <b>Diabetes</b> DUE TO (c) <b>Diabetes</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)									INTERVAL BETWEEN ONSET AND DEATH <b>unknown</b> <b>1 yr.</b> <b>2 yrs.</b>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <b>none</b>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>none</b>						
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>none</b> p.m. <b>19</b>			20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>none</b>		20f. (City or town) (County) (State) <b>none</b>		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE <b>D. D. Caples</b>			CHIEF MEDICAL EXAMINER <input type="checkbox"/>				22. DATE SIGNED		
EXAMINER'S NAME (Type) <b>D. D. Caples, M. D.</b>			6 Hanover Rd., Reisterstown, Md. Address (Street, city, town, or county)				12-18-67		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			23b. DATE THEREOF <b>12/20/67</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Baltimore Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Baltimore, Maryland</b>		
24. FUNERAL DIRECTOR <b>H. J. Eckhardt</b> ADDRESS <b>Owings Mills, Md.</b>					25a. REC'D BY REGISTRAR <b>DEC 20 1967</b>		25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>		



# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME  
6M 1/67

16540

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10542

1 PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived) f. Institution Residence before admission a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> <b>1627 N. Broadway, Balto 13, Maryland</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>St. Josephs Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First Middle Last <b>Lillie Harrison</b>		4. DATE OF DEATH Month Day Year <b>12 20 1967</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>colored</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> W. DOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>4-11-1907</b>
9. AGE (In years last birthday) yrs <b>60</b>		10. IF UNDER 1 YEAR Months Days Hours Min <b>12 20 1967</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Day work</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Levin Teagle</b>		14. MOTHER'S MAIDEN NAME <b>Laura Teagle</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO	
17. INFORMANT <b>Records</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Myocardial Infarction</b> DUE TO <b>5+ yrs</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) <b>W. H. H. Metabolism</b> DUE TO <b>14 yrs</b> (c) <b>Obesity - 10 lbs over normal</b>			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></b>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month Day Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, factory, street, office bldg, etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspect an <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Charles F. O'Donnell</b> M.D.		22. DATE SIGNED <b>12/20/67</b>	
EXAMINER'S NAME (Type) <b>Charles F. O'Donnell, M.D.</b>		Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>12/23/67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Carroll Memorial</b>	23d. LOCATION (City or Town) (County) (State) <b>Laurel Md.</b>
24. FUNERAL DIRECTOR <b>Miller E. Elchorn</b>		25a. REC'D BY REGISTRAR <b>1/29/68</b>	
ADDRESS <b>11297 Kirovsky</b>		25b. REGISTRAR'S SIGNATURE <b>James J. J...</b>	

of





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

<div> <div>16500</div> <div> <div>MARYLAND STATE DEPARTMENT OF HEALTH</div> <div>DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201</div> </div> <div>16543</div> </div>									
CERTIFICATE OF DEATH									
1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fort Howard</u>			c. LENGTH OF STAY IN 1b <u>185 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Veterans Administration Hospital</u>					d. STREET ADDRESS <u>225 N. Carrollton Avenue</u>			e. RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>JAMES LEON HARVEY</u>					4. DATE OF DEATH Month Day Year <u>Dec. 28 19 67</u>				
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Negro</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>2/13/13</u>		9. AGE (In years last birthday) yrs <u>54</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Store Keeper</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Self Employed</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Americus, Ga.</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Grady Harvey</u>					14. MOTHER'S MAIDEN NAME <u>Sallie Americus</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>Yes WW-II</u>			16. SOCIAL SECURITY NO <u>214 01 20 24</u>		17. INFORMANT Address <u>Clinical Rcds VA Hospital, Fort Howard, Md.</u>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARCINOMA OF RECTUM WITH METASTASIS</u> DUE TO 134X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost DUE TO (b) (c)									INTERVAL BETWEEN ONSET AND DEATH <u>UNKNOWN</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)									19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>June 26, 19 67</u> to <u>Dec. 28, 1967</u> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>Dec. 28 19 67</u> and that death occurred at <u>8 P.M.</u> from causes and on the date stated above.									
22a. SIGNATURE <u>George McElfatrick M.D.</u>					ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS <input type="checkbox"/>			22b. DATE SIGNED <u>12/29/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>GEORGE MCELFATRICK, M.D.</u>					22d. ADDRESS <u>VA Hospital, Fort Howard, Md.</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>1-2-68</u>		23c. NAME OF CEMETERY OR CREMATORY <u>St. Calvary Cemetery Baltimore National</u>			23d. LOCATION (City or Town) (County) (State) <u>Baltimore, Maryland</u>		
24. FUNERAL DIRECTOR <u>Randolph J. Collick</u> COLLICK FUNERAL HOME					25a. REC'D BY REGISTRAR DATE <u>JAN 2 1968</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		



# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form DM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

16551

16544

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if inst. in Res. before admission) a. STATE <b>Virginia</b> b. COUNTY <b>?</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural - Baltimore</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Virginia Beach</b>	
c. LENGTH OF STAY IN lb <b>Minutes.</b>		d. STREET ADDRESS <b>24 Spartin St.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Old York Road</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Daniel C. Hawkins</b>		4. DATE OF DEATH Month <b>12</b> Day <b>23</b> Year <b>67</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>Feb. 3, 1927</b>
9. AGE (In years last birthday) <b>40</b> yrs		10. IF UNDER YEAR IF UNDER 24 HRS Months <b>23</b> Days <b>19</b> Hours <b>67</b> Min	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Cabinetmaker</b>		12. BIRTHPLACE (State or foreign country) <b>Baltimore, Md.</b>	
13. FATHER'S NAME <b>H. C. Hawkins</b>		14. MOTHER'S MAIDEN NAME <b>Susie Saunders</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO <b>WWII 1945-1947 528-361914</b>	
17. CAUSE OF DEATH (Enter only one cause per PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a). <b>Whiplash injury of neck</b>		18. INTERVAL BETWEEN ONSET AND DEATH	
DUE TO (b). Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost DUE TO (c).			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <b>Driver in auto that overturned</b>	
20c. TIME OF INJURY Month, Day, Year <b>12:45 xx 12 23 19 67</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office, bldg., etc.) <b>Street</b>		20f. (City or town) (County) (State) <b>Baltimore Baltimore, Md.</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Werner U. Spitz, M.D.</b>		22. DATE SIGNED <b>12-23-67</b>	
EXAMINER'S NAME (Type)		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
		Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Dec. 26, 1967</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Wiseburn Cemetery</b>		23d. LOCATION (City or town) (County) (State) <b>White Hall, Md.</b>	
24. FUNERAL DIRECTOR <b>Jacob Hartenstein, New Freedom, Pa.</b>		25a. REC'D BY REGISTRAR <b>DEC 29 1967</b>	
		25b. REGISTRAR'S SIGNATURE	



# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16552

## CERTIFICATE OF DEATH

16545

1 PLACE OF DEATH a COUNTY <b>Baltimore</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Towson</b> c. LENGTH OF STAY IN/1b <b>15 days</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>ST. JOSEPH HOSPITAL</b>		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a STATE <b>Maryland</b> b COUNTY <b>1</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore 21234</b> d. STREET ADDRESS <b>2615 Edgewood Ave.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First Middle Last <b>Gordon Irvin HENSCHEN</b>		4. DATE OF DEATH Month Day Year <b>December 19, 1967</b>	
5 SEX <b>Male</b>	6 COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>June 21, 1926</b>
9 AGE (In years last birthday) <b>41</b> yrs		F UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Metallurgist</b>		10b. KIND OF BUSINESS OR IND. STRY <b>Bethlehem Steel</b>	
11 BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>		12 CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13 FATHER'S NAME <b>IRVIN Henschel</b>		14 MOTHER'S MAIDEN NAME <b>ELISE WILLS</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>Yes WW II</b>		16 SOCIAL SECURITY NO. <b>219-16-4663</b>	
17. INFORMANT <b>Catherine Henschel</b>		Address <b>Same</b>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <b>Metastatic brain tumor</b> <b>180x</b> DUE TO (b) <b>Hypernephroma</b> DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20x. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>12/4/</b> , 19 <b>67</b> , to <b>12/19/</b> , 19 <b>67</b> that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>12/19/</b> , 19 <b>67</b> , and that death occurred at <b>1:10 PM</b> , from causes and on the date stated above.			
22a. SIGNATURE <b>B. Olivos</b>		22b. DATE SIGNED <b>12/19/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>B. Olivos, M.D.</b>		22d. ADDRESS <b>7620 York Rd., Towson, Md., 21204</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF <b>12-23-67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Greenwood Fair</b>	23d. LOCATION (City or Town) (County) (State) <b>Baltimore Md</b>
24 FUNERAL DIRECTOR <b>Chas. T. Evans</b>		25a. REC'D BY REGISTRAR <b>DEC 26 1967</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AIS (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

16553

16546

1 PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>		c. LENGTH OF STAY IN 1b <u>20 DAYS</u>	
d. NAME OF HOSPITAL OR INST. (If not in hospital, give street address) <u>Greater Balt. Med. Center</u>		d. STREET ADDRESS <u>7631 Belair Road</u>	
3. NAME OF DECEASED (Type or print) <u>Barbara Catherine Ketchick</u>		4. DATE OF DEATH Month <u>12</u> Day <u>28</u> Year <u>1967</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Cauc.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-25-1903</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Telephone Operator</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Exp. Telephone Co.</u>	
11. BIRTHPLACE (County & State or foreign country) <u>Baltimore, MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Louis Stalman, (Dec.)</u>		14. MOTHER'S MAIDEN NAME <u>Barbara Schenker</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NA</u> (If yes give war or dates of service) <u>NA</u>		16. SOCIAL SECURITY NO <u>NA</u>	
17. INFORMANT <u>Admission Sheet</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Respiratory failure</u> DUE TO (b) <u>Oligoblastoma multiforme</u> DUE TO <u>Pain</u>			INTERVAL BETWEEN ONSET AND DEATH <u>5 min.</u> <u>3 months</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			9. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>12-9-1967</u> to <u>12-29-1967</u> , that (I) (we) last saw the deceased alive on <u>12-29-1967</u> , and that death occurred at <u>8:45 PM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>MA. JOSEFINA A. DE CASTRO</u>		22b. DATE SIGNED <u>12-29-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>MA. JOSEFINA A. DE CASTRO</u>		22d. ADDRESS <u>GBMC</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>1-3-1968</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Holy Redeemer Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Baltimore City Md.</u>
24. FUNERAL DIRECTOR <u>Lassahn Funeral Home</u>		25a. REC'D BY REGISTRAR <u>JAN 3 1968</u>	
ADDRESS <u>7411 Belair Road</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	





16554

## CERTIFICATE OF DEATH

16547

1 PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside of corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Spring Grove State Hosp</b>		d. STREET ADDRESS <b>1019 Scotts Hill Drive</b>	
3 NAME OF DECEASED (Type or print) <b>Joseph</b> First Middle Last		4 DATE OF DEATH <b>12</b> Month <b>16</b> Day <b>1967</b> Year	
5 SEX <b>MALE</b>	6 COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8 DATE OF BIRTH <b>1932</b>
10a. USUAL OCC. PAT ON (Give kind of work done during most of working life, even if retired) <b>XXXXXXXXXXXXXXXXXXXX</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>ATTORNEY</b>	9 AGE (In years last birthday) <b>35</b> yrs.
11 BIRTHPLACE (County & State, or foreign country) <b>Russia</b>		12 CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>MOSES HETTMAN</b>		14. MOTHER'S MAIDEN NAME	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <b>NO</b> (If yes give war or dates of service)		16. SOCIAL SECURITY NO <b>219-32-1954A</b>	
17 INFORMANT <b>MR. EUGENE HETTMAN</b>		Address <b>1015 SCOTTS HILL DR.</b> #8	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Myocardial infarction</b> DUE TO <b>Arteriosclerotic cardiovascular disease -</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>hypertension</b> DUE TO <b>hypertension</b> (b) <b>hypertension</b> (c) <b>hypertension</b>		INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21 I certify that (I) (this hospital) attended the deceased from <b>8 31, 1967</b> , to <b>12 16, 1967</b> , that (I) (we) last saw the deceased alive on <b>12 16, 1967</b> , and that death occurred at <b>12 16 PM</b> , from causes on and on the date stated above.			
22a. SIGNATURE <b>George A. Rodon M.D.</b>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <b>George A. Rodon M.D.</b>		22d. ADDRESS <b>SPRING GROVE STATE HOSP.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE THEREOF <b>12-18-67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>ANSHE EMUNAH AITZ CHAIM</b>	23d. LOCATION (City or town) (County) (State) <b>BALTIMORE, MARYLAND</b>
24 FUNERAL DIRECTOR <b>SOL LEVINSON &amp; BROS. INC., 6010 REISTERSTOWN RD.</b>		25a. REC'D BY REGISTRAR <b>DEC 20 1967</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Jones</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



16555

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

13548

1 PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Carney</u>		c. LENGTH OF STAY IN 1b <u>Baltimore</u> 21234	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>3416 E. Joppa Road</u>		d. STREET ADDRESS <u>3416 E. Joppa Road</u>	
3 NAME OF DECEASED (Type or print) First <u>Peter</u> Middle <u>N.</u> Last <u>Hiebler</u>		4 DATE OF DEATH Month <u>December</u> Day <u>26</u> Year <u>1967</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 8, 1912</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Chauffeur</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Public Schools</u>	9. AGE (In years last birthday) <u>55</u> yrs
11 BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12 CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13 FATHER'S NAME <u>Phillip J. Hiebler</u>		14. MOTHER'S MAIDEN NAME <u>Catherine Knox</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u>215-05-8754</u>	
17. INFORMANT <u>Mrs. Camille Hiebler</u>		Address <u>(Same)</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute myocardial infarction</u> DUE TO (b) <u>Arteriosclerotic cardiovascular disease</u> DUE TO (c) <u>Severe</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH <u>16 months</u> <u>7 years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)
20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>Oct 19, 1966</u> to <u>Dec 19, 1967</u> that (I) (we) last saw the deceased alive on <u>Dec 19, 1967</u> , and that death occurred at <u>4:45 p.m.</u> from causes on and on the date stated above.			
22a. SIGNATURE <u>Seymour H. Rubin</u>		22b. DATE SIGNED <u>12/27/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Seymour H. Rubin, M.D.</u>		22d. ADDRESS <u>5415 Park Heights Ave</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>12/30/67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Parkwood Cem.</u>		23d. LOCATION (City or Town) (County) (State) <u>Balto. Md.</u>	
24. FUNERAL DIRECTOR <u>Leonard J. Ruck, Inc. Balto. Md. 21214</u>		25a. REC'D BY REGISTRAR DATE <u>DEC 28 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16556

CERTIFICATE OF DEATH

10549

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. LENGTH OF STAY IN 1b <b>lyrl1mth3dys</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>4208 White Avenue - Overlea, Md.</b>		d. STREET ADDRESS <b>4208 White Avenue</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>SPRING GROVE STATE HOSPITAL</b>		e. RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Margaret</b> Middle <b>Holland</b> Last <b>Holland</b>		4. DATE OF DEATH Month <b>December</b> Day <b>4</b> Year <b>1967</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Jan. 18, 1887</b>
9. AGE (In years last birthday) <b>80 yrs.</b>		10. IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min <b>0</b>	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>		11b. KIND OF BUSINESS OR INDUSTRY <b>home</b>	
12. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>		13. CITIZEN OF WHAT COUNTRY? <b>U. S.</b>	
14. FATHER'S NAME <b>William Harman</b>		15. MOTHER'S MAIDEN NAME <b>Caroline Appold</b>	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>		17. SOCIAL SECURITY NO. <b>219-54-3164-J1</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Infarction</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic Cardiovascular Ht. Dis.</b> DUE TO (c) <b>Arteriosclerosis, Generalized, Senile</b>		INTERVAL BETWEEN ONSET AND DEATH <b>1 yr.</b> <b>2 yrs.</b> <b>10 yrs.</b>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Diabetes Mellitus</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat While <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>Dec. 31, 1965</b> , to <b>Dec. 4, 1967</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>Dec. 4, 1967</b> , and that death occurred at <b>7:30</b> M, from causes and on the date stated above.			
22a. SIGNATURE <i>Anthony J. Young</i> M.D.		22b. DATE SIGNED <b>12-4-67</b>	
22c. PHYSICIAN'S NAME (Type) <b>Anthony J. Young, M.D.</b>		22d. ADDRESS <b>SPRING GROVE STATE HOSPITAL Baltimore, Maryland 21228</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>Dec. 7, 1967</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Lorraine Park Cemetery</b>	23d. LOCATION (City or Town) (County) (State) <b>Woodlawn, Maryland</b>
24. FUNERAL DIRECTOR <b>Wm. Cook-Brooks Towson, 1050 York Road Towson, Maryland 21204</b>		25a. REC'D BY REGISTRAR <b>DEC 7 1967</b>	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201			
16557		16550	
PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b> c. LENGTH OF STAY IN b <b>16</b>		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Summit Nursing Home</b>		d. STREET ADDRESS <b>Roland Ave. &amp; Rectory Lane</b> e. IS RESIDENCE ON A FARM? <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>MARGARETTA R. HOLLYDAY</b>		4. DATE OF DEATH Month <b>December</b> Day <b>26</b> Year <b>67</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 23, 1884</b> 9. AGE (In years last birthday) <b>83</b> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Hostess</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Retired</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Easton, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Henry Hollyday</b>		14. MOTHER'S MAIDEN NAME <b>Margaretta Chilton</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO <b>217-05-9963</b>	
17. INFORMANT <b>A Miss Rosalie Hollyday Memorial Apt</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of thyroid</b> DUE TO (b) <b>1942</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost <b>1942</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>4 months</b>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>Oct 1967</b> , to <b>Dec 26, 1967</b> , that (I) ( <del>was</del> ) last saw the deceased alive on <b>Dec 26, 1967</b> , and that death occurred at <b>3:00 P.M.</b> from causes and on the date stated above.			
22a. SIGNATURE <b>John A. Nesbitt, Jr.</b>		22b. DATE SIGNED <b>12-26-67</b>	
22c. PHYSICIAN'S NAME (Type) <b>JOHN A. NESBITT, JR.</b>		22d. ADDRESS <b>1009 Frederick Rd. Balt. 2122A</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>12-29-67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Spring Hill</b>	23d. LOCATION (City or Town) (County) (State) <b>Easton, Maryland</b>
24. FUNERAL DIRECTOR <b>Mitchell-Wiedefeld Home, Inc., 6500 York Rd. Baltimore, Md. 21212</b>		ADDRESS <b>6500 York Rd. Baltimore, Md. 21212</b> DATE <b>3 1968</b>	





16558

## CERTIFICATE OF DEATH

16551

1 PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Jullerton</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>22 Mc Cormick Avenue</u>		d. STREET ADDRESS <u>22 Mc Cormick Ave.</u>	
3 NAME OF DECEASED (Type or print) First <u>Francis</u> Middle <u>E.</u> Last <u>Holmes</u>		4 DATE OF DEATH Month <u>December</u> Day <u>31</u> Year <u>1967</u>	
5 SEX <u>Male</u>	6 COLOR OR RACE <u>white</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 AGE (In years last birthday) <u>69</u> yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Machinist (Ret.)</u>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State or foreign country) <u>Connecticut</u>
13 FATHER'S NAME <u>Francis H. Holmes</u>		14. MOTHER'S MAIDEN NAME <u>Laura M. Harvey</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16 SOCIAL SECURITY NO <u>042091875</u>	17 INFORMANT <u>Mrs. Alma E. Holmes- Same</u>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute coronary myocardial infarction</u> + DVI DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic cardiovascular disease</u> DUE TO (c) <u>with coronary insufficiency</u>			INTERVAL BETWEEN ONSET AND DEATH <u>20 min.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>Sept</u> , 19 <u>67</u> , to <u>Dec</u> , 19 <u>67</u> , that (I) <del>(we)</del> last saw the deceased alive on <u>Dec 18</u> , 19 <u>67</u> , and that death occurred at <u>5:15 PM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Charles M. Kerr</u> MD		ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>	22b. DATE SIGNED <u>Jan 2, 67</u>
22c. PHYSICIAN'S NAME (Type) <u>Charles M. Kerr</u>		22d. ADDRESS <u>6801 Belair Rd. B2746 Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>1/4/68</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Moreland Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Baltimore Co., Maryland</u>
24 FUNERAL DIRECTOR <u>Leonard J. Ruck, Inc. Balto. Md. 21214</u>		25a. REC'D BY REGISTRAR DATE <u>AN 4 1968</u>	25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 2 and 4, and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

16550

16552

1 PLACE OF DEATH a. COUNTY <i>Baltimore</i>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Towson</i>		c. LENGTH OF STAY IN 1b <i>10 days</i>		2 USUAL RESIDENCE (Where deceased lived, if institut on Residence before admission) a. STATE <i>Md</i>		b. COUNTY <i>Harford</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Greater Baltimore Med. Center</i>		e. STREET ADDRESS <i>11 N Kelly Ave.</i>		f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3 NAME OF DECEASED (Type or print) <i>Ethel Wineford Hopkins</i>		4 DATE OF DEATH Month <i>12</i> Day <i>22</i> Year <i>1967</i>		5 SEX <i>F</i>		6 COLOR OR RACE <i>Can</i>		7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8 DATE OF BIRTH <i>1-21-07</i>		9 AGE (In years last birthday) <i>60</i> yrs		10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b KIND OF BUSINESS OR INDUSTRY <i>None</i>		11 BIRTHPLACE (County & State or foreign country) <i>Delta, Pa.</i>	
12 CITIZEN OF WHAT COUNTRY? <i>USA</i>		13 FATHER'S NAME <i>Edward Hughes</i>		14 MOTHER'S MAIDEN NAME <i>Lloyd.</i>		15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <i>No</i>			
16 SOCIAL SECURITY NO. <i>UNK</i>		17 INFORMANT <i>Harold R. Hopkins</i>		Address <i>11 N. Kelly Ave Bel Air, Md.</i>					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Bronchopneumonia</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <i>Secondary to Pulmonary metastasis</i> DUE TO (c) <i>Secondary to CARCINOMA BREAST.</i>								INTERVAL BETWEEN ONSET AND DEATH <i>12/13/67</i> <i>12/22/67</i>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE FATAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c TIME OF INJURY Month, Day, Year Hour 'o.m. p.m. <i>19</i>				20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>12-13-1967</i> to <i>12-22-1967</i> , that (I) (we) last saw the deceased alive on <i>12-22-1967</i> , and that death occurred at <i>12-10AM</i> , from causes and on the date stated above.									
22a. SIGNATURE <i>Dipak Kumar Mallik</i>				M.D. ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22b. DATE SIGNED <i>Dec. 22, 1967</i>			
22c. PHYSICIAN'S NAME (Type) <i>DIPAK KUMAR MALLIK</i>				22d. ADDRESS <i>Greater Baltimore Medical Center</i>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>Dec. 24, 1967</i>		23c. NAME OF CEMETERY OR CREMATORY <i>State Ridge Cemetery</i>		23d. LOCATION (City or Town) (County) (State) <i>Delta York Pa.</i>			
24. FUNERAL DIRECTOR <i>John H. Harkins</i>				ADDRESS <i>Delta, Pa.</i>		25a. RECEIVED BY REGISTRAR <i>DEC 27 1967</i>		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>	



## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

16553

FOR STATE  
HEALTH DEPT.

16560

1 PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <b>Dundalk</b>		c. LENGTH OF STAY IN 1b <b>One Year</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>7929 Lynch Road</b>		e. STREET ADDRESS <b>7929 Lynch Road</b>	
3 NAME OF DECEASED (Type or print) First Middle Last <b>Gladys Fannie Howard</b>		4 DATE OF DEATH Month Day Year <b>December 6 19 67</b>	
5 SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 12, 1901</b>
9 AGE <b>66</b> yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>	
11 BIRTHPLACE (State or foreign country) <b>West Virginia</b>		12 CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13 FATHER'S NAME <b>Charles Whittke</b>		14 MOTHER'S M A D E N NAME <b>Ella Childres</b>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16 SOCIAL SECURITY NO <b>234-38-6633D</b>	
17 INFORMANT (Daughter) <b>Mrs. Edna E. McCartney, 7929 Lynch Rd.</b>		Address <b>Dundalk, Md.</b>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY <b>1561</b> IMMEDIATE CAUSE (a) <b>CARCINOMA OF LIVER</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) (c) INTERVAL BETWEEN ONSET AND DEATH <b>10 mos</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <b>None</b>	
20c. TIME OF INJURY Month, Day Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office, etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Melvin B. Davis</b> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> <b>3800 Morningside Rd.</b>	
EXAMINER'S NAME (Type) <b>Melvin B. Davis</b> M.D.		ASSISTANT MED. CA. EXAMINER <input type="checkbox"/> <b>Dundalk,</b>	
		DEPUTY MED. CA. EXAMINER <input checked="" type="checkbox"/> <b>Md. 21222</b> <b>12/6/67</b>	
23a. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>12/9/67</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Lake View Memorial Park</b>		23d. LOCATION (City or town) (County) (State) <b>Carroll Co. Md.</b>	
24. FUNERAL DIRECTOR ADDRESS <b>John J. Duda, 7922 Wise Ave. Dundalk, Md.</b>		25a. REC'D BY REGISTRAR <b>DEC 11 1967</b>	
		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.



## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

16554

FOR STATE  
HEALTH DEPT.

1

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 PLACE OF DEATH a. COUNTY <b>Balto.</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Lutherville</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Lutherville</b>		c. LENGTH OF STAY IN days <b>days</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>506 Seminary Ave.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) <b>LORRIE ANN HOWARD</b>		4 DATE OF DEATH Month <b>December</b> Day <b>11</b> Year <b>1967</b>	
5 SEX <b>Female</b>	6 COLOR OR RACE <b>White</b>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>Oct. 25, 1967</b>
9 AGE (In years lost birthday) <b>795.5</b>		10 FUND 1 YEAR IF UNDER 24 HRS Months <b>3</b> Days <b>16</b> Hours <b>16</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>N/A</b>	
11 BIRTHPLACE (State or foreign country) <b>Maryland</b>		12 CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>George Howard</b>		14 MOTHER'S MAIDEN NAME <b>Loretta Ross</b>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16 SOCIAL SECURITY NO <b>Mr. Goerge Howard, Same as # 2</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Sudden unexpected death in infancy</b> 795.5 DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (c) _____			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1B)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Edward F. Wilson</b>		22. DATE SIGNED <b>December 11, 1967</b>	
EXAMINER'S NAME (Type) <b>Edward F. Wilson, M.D.</b>		Address (Street, city, town, or county) <b>Cockeysville, Maryland</b>	
23a. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>Dec. 14, 1967</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Dulaney Valley Cemetery</b>	23d. LOCATION (City or town) (County) (State) <b>Cockeysville, Maryland</b>
24 FUNERAL DIRECTOR <b>Wm. Cook-Brooks Towson, 1050 York Road, Towson, Md. 21204</b>		25a. REC'D BY REGISTRAR <b>DEC 19 1967</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			





FOR STATE  
HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

16562										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										11889									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH																													
1 DECEASED-NAME (Type or Print)		First		Middle		Last				2a DATE KNOWN OF DEATH		ESTIMATED Month		Day		Year		2b HOUR											
CLYDE		Allison		ISENNOCK						12		4		19		67													
3 SEX		4 RACE		5 DATE OF BIRTH		6 AGE (in years last birthday)		7 UNDER 1 YEAR		8 OVER 1 YEAR		9 MONTHS		10 DAYS		11 HOURS		12 MIN		2c DATE PRONOUNCED DEAD		2d HOUR							
Male		White		2/9/1904		63 YRS		11												1		5:10							
7a BIRTHPLACE (State or foreign country)				7b CITIZEN OF WHAT COUNTRY?				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>				9. COUNTY OF DEATH																	
Maryland				U.S.A.				WIDDED <input type="checkbox"/> SEPARATED <input checked="" type="checkbox"/>				Baltimore																	
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address)				12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)				12b KIND OF BUSINESS OR INDUSTRY																	
Parkton				about 100 ft. W of Rt. 45				Laborer				Farm																	
13a U.S.A. RESIDENCE (Where deceased admission) STATE				13b. COUNTY				13c. CITY OR TOWN				13d. INSIDE CITY LIMITS?				13e. STREET AND NUMBER													
Maryland				Baltimore				Hyde				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				Unknown													
14 FATHER'S NAME		First		Middle		Last		15. MOTHER'S MAIDEN NAME		First		Middle		Last															
John Thomas		Isennock						Victorine		Coe																			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16b SOCIAL SECURITY NO				16c INFORMANT				16d ADDRESS																	
No				193-18-5519				Mrs. William E. Standiford				117 Gibbons Blvd. 21030				Cockeysville, Md.													
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)																		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Asphyxia due to hanging																													
DUE TO, OR AS A CONSEQUENCE OF																													
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.																													
(b) DUE TO, OR AS A CONSEQUENCE OF																													
(c) DUE TO, OR AS A CONSEQUENCE OF																													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																													
19a DATE OF OPERATION										19b CONDITION FOR WHICH OPERATION WAS PERFORMED?										20 AUTOPSY?									
																				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
21a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/>					21b TIME OF INJURY Month, Day, Year HOUR A.M. ? P.M. ? 19					21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 18)																			
CAUSE OF DEATH					? P.M. ? 19					Subject hanged himself																			
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>					21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)					21f LOCATION Street or R.F.D. No					City or Town					County		State							
Tree										100 ft. W of Rt. 45					Baltimore					Balto.		Md.							
22a I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>																													
ACTUAL SIGNATURE										CHIEF MEDICAL EXAMINER <input type="checkbox"/>										22b. DATE SIGNED									
EXAMINER'S NAME (Type)										ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>										January 17, 1968									
Edward F. Wilson, M.D.										DEPUTY MEDICAL EXAMINER <input type="checkbox"/>																			
										ADDRESS (Street, city, town, or county)																			
23a BURIAL, CREMATION, REMOVAL (Specify)					23b DATE					23c NAME OF CEMETERY OR CREMATORY					23d. LOCATION (City or Town)					(County)		(State)							
Burial					1/19/1968					Ebenezer					Rutledge, Harford, Md.														
24 FUNERAL DIRECTOR										ADDRESS										25a REC'D BY REGISTRAR					25b. REGISTRAR'S SIGNATURE				
Charles E. Kurtz										Jarrettsville, Md.										JAN 19 1968									



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.


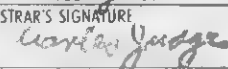
VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

16563

16555

1 PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>---</b>			
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>TOWSON</b>			c LENGTH OF STAY IN 1b			c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BALTIMORE</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>ST. JOSEPH HOSPITAL</b>				d STREET ADDRESS <b>4307 GLEN ARM AVE. #21206</b>			e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3 NAME OF DECEASED (Type or print) First Middle Last <b>RICHARD RAYMOND JENKINS</b>				4. DATE OF DEATH <b>DECEMBER 24 1967</b> Month Day Year			
5 SEX <b>MALE</b>	6 COLOR OR RACE <b>WHITE</b>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>DECEMBER 15, 1889</b>		9. AGE (In years lost birthday) <b>78 yrs.</b>		IF UNDER 1 YEAR Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Assist. Agent Penna. R.R.</b>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State or foreign country) <b>BALTIMORE, MARYLAND</b>		12 CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>William Jenkins</b>				14. MOTHER'S MAIDEN NAME <b>Katherine</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>717-07-9522</b>		17. INFORMANT <b>Mrs Pearl Jenkins</b>		Address <b>Same</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>ACUTE PULMONARY EDEMA</b> DUE TO (b) <b>CONGESTIVE HEART FAILURE</b> DUE TO (c) <b>EMPHYSEMA</b>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>DECEMBER 23, 1967</b> , to <b>DECEMBER 24, 1967</b> that (I) (we) last saw the deceased alive on <b>DECEMBER 24, 1967</b> , and that death occurred at <b>3:00AM</b> from causes on and on the date stated above							
22a. SIGNATURE 				22b. DATE SIGNED <b>DECEMBER 24, 1967</b>		22c. PHYSICIAN'S NAME (Type) <b>ISMAEL JAMORA, M.D.</b>	
22d. ADDRESS <b>7620 YORK ROAD TOWSON, MARYLAND</b>							
23a. BURIAL, CREMA, ON, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>12/27/67</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Moreland Memorial</b>		23d. LOCATION (City or Town) (County) (State) <b>Baltimore Maryland</b>	
24. FUNERAL DIRECTOR <b>Leonard J Ruck Inc. 5305 Harford Rd.</b>				25a. REC'D BY REGISTRAR <b>DATE DEC 27 1967</b>		25b. REGISTRAR'S SIGNATURE 	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
16564 CERTIFICATE OF DEATH 16566											
1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Howard</u>					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>						c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Ellicott City</u>					
c. LENGTH OF STAY IN 1b						d. STREET ADDRESS <u>Folly Quarter Rd.</u>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Shangri La. Nursing Home</u>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First <u>Allan</u> Middle <u>Johnson</u> Last						4. DATE OF DEATH Month <u>Dec.</u> Day <u>5</u> Year <u>1967</u>					
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>5/6/88</u>		9. AGE (In years last birthday) <u>79</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Med. Director</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Doctor</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Mass</u>				12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Frederick Johnson</u>						14. MOTHER'S MAIDEN NAME <u>Ella Kimball</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>				16. SOCIAL SECURITY NO. <u>?</u>		17. INFORMANT <u>Mrs. Mary Bennett Ellibott City, Md.</u>				Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> <u>446X</u> DUE TO (b) <u>Nephrosclerosis</u> DUE TO (c) <u>Generalized Arteriosclerosis</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>CVA in L. side Hemiparesis</u>											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)											
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>10-1-1967</u> to <u>12-6-1967</u> , that (I) (we) last saw the deceased alive on <u>12-5-1967</u> , and that death occurred at <u>3 P.M.</u> from the causes and on the date stated above.											
22a. SIGNATURE <u>Dean Valle Caverio</u>						M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>12-6-67</u>			
22c. PHYSICIAN'S NAME (Type) <u>CESAR VALLE CAVERIO</u>						22d. ADDRESS <u>8629 Liberty Rd. Rockville, Md.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		23b. DATE THEREOF <u>12-6-67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>LEE FUNERAL Home</u>		23d. LOCATION (City, town or county) (State) <u>Washington, DC</u>					
24. FUNERAL DIRECTOR <u>Higdon &amp; Sons SIA - 11444 Ellicott City</u> <u>Funeral Home</u>						25a. REC'D BY REGISTRAR DATE <u>DEC 11 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			



16565

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

16557

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>BALTO.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. LENGTH OF STAY IN 1b <b>905 Bengies Rd.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>FOREST HAVEN NURSING HOME</b>		d. STREET ADDRESS <b>905 Bengies Rd.</b>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>ANNIE E JONES</b>		4. DATE OF DEATH Month Day Year <b>Dec. 29 1967</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov. 29 1888</b>
9. AGE (in years last birthday) <b>79</b> yrs		10. BIRTHPLACE (County & State, or foreign country) <b>MARYLAND</b>	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>AT HOME</b>		11b. KIND OF BUSINESS OR INDUSTRY	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME <b>JOHN WANDBY</b>	
14. MOTHER'S MÄDEN NAME <b>MARY GENRING</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	
16. SOCIAL SECURITY NO <b>213-05-3776</b>		17. INFORMANT <b>MRS ALTHEA V. OBERLE-905 BENGIES RD</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>4201</b> DUE TO <b>444 JENNERAL INFARCTION</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>MURDERED SOLICITOR - CHARGE - VIOLENCE</b> DUE TO (c) <b>DISEASE</b>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (the hospital) attended the deceased from <b>11/1</b> 19 <b>67</b> to <b>12/29</b> 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>11/29</b> 19 <b>67</b> , and that death occurred at <b>2:30 PM</b> , from causes and on the date stated above.			
22a. SIGNATURE <b>John A. Shaw</b>		22b. DATE SIGNED <b>12/29/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>John A. Shaw</b>		22d. ADDRESS <b>6507 ELLSWORTH AVE. BALTIMORE, MD</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE THEREOF <b>1/2/68</b>	23c. NAME OF CEMETERY OR CREMATORY <b>OAK LAWN</b>	23d. LOCATION (City or Town) (County) (State) <b>COLGATE MD</b>
24. FUNERAL DIRECTOR <b>Raymond J. Hughes</b>		25a. REC'D BY REG. STRAR <b>PMS</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles J. Judge</b>		DATE <b>JAN 5 1968</b>	





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

16566

10558

1 PLACE OF DEATH a COUNTY <b>BALTIMORE</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a STATE <b>MARYLAND</b> b COUNTY <b>DORCHESTER</b>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FORT HOWARD</b>		c LENGTH OF STAY IN 1b <b>26 DAYS</b>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>VETERANS ADMINISTRATION HOSPITAL</b>		e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First Middle Last <b>BERNARD M. JONES</b>		4 DATE OF DEATH Month Day Year <b>DECEMBER 6 19 67</b>	
5 SEX <b>MALE</b>	6 COLOR OR RACE <b>WHITE</b>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>3/11/1901</b>
9. AGE (In years last birthday) yrs <b>66</b>		10. IF UNDER 1 YEAR Months Days Hours Min	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>BUTCHER</b>		10b KIND OF BUSINESS OR INDUSTRY <b>Grocery Store</b>	
11 BIRTHPLACE (County & State, or foreign country) <b>DORCHESTER CO. MARYLAND</b>		12 CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13 FATHER'S NAME <b>FIELDER G. JONES</b>		14 MOTHER'S MAIDEN NAME <b>LILLIE PARTRIDGE</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>YES WW I</b>		16. SOCIAL SECURITY NO <b>215 03 54 60</b>	
17 INFORMANT <b>CLIN. RECORDS, VA HOSPITAL, FT HOWARD, MD.</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>ADENOCARCINOMA OF PROSTATE WITH METASTASES</b> DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ INTERVAL BETWEEN ONSET AND DEATH <b>71X MONTHS</b>			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19 WAS ALTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. _____ 19____	20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>11/10/67</b> , 19____, to <b>12/6/67</b> , 19____, that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>12/6/67</b> , 19____, and that death occurred at <b>2:50P.M.</b> from causes and on the date stated above.			
22a SIGNATURE <i>George Dudas</i>		22b DATE SIGNED <b>12/6/67</b>	
22c PHYSICIAN'S NAME (Type) <b>GEORGE DUDAS, M. D.</b>		22d ADDRESS <b>VAH FORT HOWARD, MARYLAND</b>	
23a BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b DATE THEREOF <b>Dec 9, 1967</b>	23c NAME OF CEMETERY OR CREMATORY <b>Greenlawn Cemetery</b>	23d LOCATION (City or Town) (County) (State) <b>Cambridge, Maryland</b>
24. FUNERAL DIRECTOR		25a REC'D BY REGISTRAR <b>DEC 11 1967</b>	
ADDRESS <b>LECOMPT FURNAL HOME</b>		25b REGISTRAR'S SIGNATURE <i>Charles Judge</i>	
<b>CAMBRIDGE, MARYLAND</b>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 4-64

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b> c. LENGTH OF STAY IN 1b <b>21212</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>66 Dunkirk Road</b>						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore 21212</b> d. STREET ADDRESS <b>66 Dunkirk Road</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First <b>George</b> Middle <b>T.</b> Last <b>Jones</b>						4. DATE OF DEATH Month <b>Dec</b> Day <b>12</b> Year <b>19 67</b>					
5. SEX <b>M</b>		6. COLOR OR RACE <b>W</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>3-19-1879</b>		9. AGE (In years last birthday) <b>88</b> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <b>8</b> Days <b>12</b> Hours <b>12</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Auto Repair-Owner</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Garage</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Baltimore, Md.</b>			12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		
13. FATHER'S NAME <b>William Thomas Jones</b>						14. MOTHER'S MAIDEN NAME <b>Mary E. McCullough</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes give war or dates of service)				16. SOCIAL SECURITY NO. <b>218-54-3917</b>		17. INFORMANT <b>Mrs. Harry Runyan</b> Address <b>Above</b>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>4201</b> <b>Coronary Occlusion</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <b>QUE TO</b> (c) <b>DUE TO</b>										INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>Nov 15</b> to <b>Dec 12</b> , 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>Dec 11</b> , 19 <b>67</b> , and that death occurred at <b>4:20</b> M, from the causes and on the date stated above.											
22a. SIGNATURE <b>Dr. Wm. G. Helfrich</b>						M.O. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>12-13-67</b>			
22c. PHYSICIAN'S NAME (Type) <b>Dr. Wm. G. Helfrich</b>						22d. ADDRESS <b>5006 Roland Ave., Balto., Md.</b>					
23a. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>12-15-67</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Woodlawn</b>			23d. LOCATION (City, town or county) (State) <b>Woodlawn Md.</b>				
24. FUNERAL DIRECTOR <b>H.W. Jenkins &amp; Sons Co.</b> ADDRESS <b>4905 York Rd., Balto.</b>						25a. REC'D BY REGISTRAR <b>DEC 13 1967</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			



# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

16568

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

16560

1 PLACE OF DEATH a COUNTY <b>Baltimore</b> MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a STATE <b>Maryland</b> b COUNTY <b>Montgomery</b> ✓			
b CITY OR TOWN (If outside of corporate limits, write RURAL and give nearest town) <b>Owings Mills</b>		c LENGTH OF STAY IN 1b <b>8 yrs.</b>		c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b>			
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Rosewood State Hospital</b>				d STREET ADDRESS <b>Stewart Lane</b>		e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First <b>Robin</b> Middle <b>-</b> Last <b>JONES</b>				4 DATE OF DEATH Month <b>12</b> Day <b>17</b> Year <b>19 67</b>			
5 SEX <b>Female</b>	6 COLOR OR RACE <b>Negro</b>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>11-3-57</b>		9 AGE (In years last birthday) <b>10 yrs</b>	IF UNDER 1 YEAR Months <b>10</b> Days <b>10</b> Hours <b>10</b> Min <b>10</b>	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Dependent</b>		10b KIND OF BUSINESS OR INDUSTRY <b>none</b>		11 BIRTHPLACE (State or foreign country) <b>Montgomery Co., Md.</b>		12 COUNTRY OF WHAT COUNTRY? <b>U.S.A.</b>	
13 FATHER'S NAME <b>Walter Jones</b>				14 MOTHER'S MAIDEN NAME <b>Frances Louise Poge</b>			
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>		16 SOCIAL SECURITY NO. <b>none</b>		17 INFORMANT Address <b>Rosewood Records, Owings Mills, Maryland</b>			
18 CAUSE OF DEATH (Enter on any one cause per line for (a), (b) and (c)) PART I DEATH WAS CAUSED BY <b>9217</b> IMMEDIATE CAUSE (a) <b>Asphyxiation to food aspiration</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) _____ (c) _____						INTERVAL BETWEEN ONSET AND DEATH	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>aspirational pneumonia</b>						19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <b>Child aspirated food</b>					
20c TIME OF INJURY Month Day Year Hour <b>2</b> m <b>17</b> p.m. <b>19 67</b>		20d INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e PLACE OF INJURY (Home, farm, factory, street, office, etc.) <b>Rosewood State Hospital</b>		20f (City or town) (County) (State) <b>Owings Mills, Md.</b>	
21 I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>D. D. Caples</b> M.D.				22. DATE SIGNED <b>12/19/67</b>			
EXAMINER'S NAME (Type) <b>D. D. Caples, M.D.</b>				Address (Street, city, town or county) <b>Reisterstown, Maryland</b>			
23a BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b DATE THEREOF <b>12/21/67</b>		23c NAME OF CEMETERY OR CREMATORY <b>Rosewood Cemetery</b>		23d LOCATION (City or town) (County) (State) <b>Owings Mills, Md.</b>	
24. FUNERAL DIRECTOR <b>J. F. Eline &amp; Sons</b>				ADDRESS <b>Reisterstown, Md.</b>		25a. REC'D BY REGISTRAR DATE <b>DEC 26 1967</b>	
				25b. REGISTRAR'S SIGNATURE <b>John A. Judge</b>			



# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16567

## CERTIFICATE OF DEATH

16567

<b>1. PLACE OF DEATH</b> a. COUNTY <b>BALTIMORE</b> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>TOWSON</b> c. LENGTH OF STAY IN 1b Days d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>ST. JOSEPH HOSPITAL</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BALTIMORE</b> d. STREET ADDRESS <b>425 MURDOCK ROAD #21212</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
<b>3. NAME OF DECEASED</b> (Type or print) First Middle Last <b>ANNA ALICE KANE</b>				<b>4. DATE OF DEATH</b> Month Day Year <b>DECEMBER 18 1967</b>					
<b>5. SEX</b> <b>FEMALE</b>		<b>6. COLOR OR RACE</b> <b>WHITE</b>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <b>MAY 30, 1889</b>		<b>9. AGE</b> (In years lost birthday) <b>78</b> yrs IF UNDER 1 YEAR Months Days Hours Min.	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Homemaker</b>			<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Home</b>		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <b>HARRISONBURG, VA.</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.A.</b>		
<b>13. FATHER'S NAME</b> <b>Edward Lucas Russell</b>				<b>14. MOTHER'S MAIDEN NAME</b> <b>Louella Gaines</b>					
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>			<b>16. SOCIAL SECURITY NO</b> <b>220 44 0385</b>		<b>17. INFORMANT</b> <b>Mr. James E. Kane, Jr.</b> Address <b>1134 Gypsy Lane West Towson, Maryland 21204</b>				
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>CEREBRAL HEMORRHAGE GENERALIZED ARTERIOSCLEROSIS</b> DUE TO <b>ARTERIOSCLEROTIC HEART DISEASE</b> (b) DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost								<b>INTERVAL BETWEEN ONSET AND DEATH</b>	
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)</b>								<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH</b> (If either, NOTIFY MEDICAL EXAMINER)				<b>20b. DESCRIBE HOW INJURY OCCURRED</b> (Enter nature of injury in Part I or Part II of item 18.)					
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. p.m. 19		<b>20d. INJURY OCCURRED</b> While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town) (County) (State)</b>			
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <b>DECEMBER 9, 1967</b> , <b>to</b> <b>DECEMBER 18, 1967</b> <b>that (I) (we) last saw the deceased alive on</b> <b>DECEMBER 18, 1967</b> , <b>and that death occurred at</b> <b>4:20 PM</b> <b>from causes and on the date stated above.</b>									
<b>22a. SIGNATURE</b> <b>Gualberto Gokim Jr.</b>				<b>22b. DATE SIGNED</b> <b>DECEMBER 18, 1967</b>		<b>22c. PHYSICIAN'S NAME (Type)</b> <b>GUALBERTO GOKIM, JR., M.D.</b>		<b>22d. ADDRESS</b> <b>7620 YORK ROAD TOWSON, MD. #21204</b>	
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>Burial</b>		<b>23b. DATE THEREOF</b> <b>Dec. 20, 1967</b>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Druid Ridge Cemetery</b>		<b>23d. LOCATION (City or Town) (County) (State)</b> <b>Pikesville, Maryland</b>			
<b>24. FUNERAL DIRECTOR</b> <b>Wm. Cook-Brooks Towson, 1050 York Road Towson, Maryland 21204</b>				<b>25a. REC'D BY REGISTRAR</b> <b>DATE DEC 22 1967</b>		<b>25b. REGISTRAR'S SIGNATURE</b> <i>[Signature]</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16570

CERTIFICATE OF DEATH

13567

1 PLACE OF DEATH a COUNTY <u>Baltimore</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a STATE <u>Md.</u> b COUNTY <u>Baltimore</u>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c LENGTH OF STAY IN 1b	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>1805 Green Castle Drive</u>		d STREET ADDRESS <u>1805 Green Castle Drive</u>	
3 NAME OF DECEASED (Type or print) First <u>Joseph</u> Middle <u>William</u> Last <u>Kaufmann</u>		4 DATE OF DEATH Month <u>Dec.</u> Day <u>12</u> Year <u>19 67</u>	
5 SEX <u>male</u>	6 COLOR OR RACE <u>white</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>June 28, 1901</u>
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Policeman</u>		10b KIND OF BUSINESS OR INDUSTRY	9 AGE (In years last birthday) <u>66</u> yrs
11 BIRTHPLACE (County & State or foreign country) <u>Maryland</u>		12 CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13 FATHER'S NAME <u>Joseph F. Kaufmann</u>		14 MOTHER'S MAIDEN NAME <u>Sophia Scheutler</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16 SOCIAL SECURITY NO <u>220-36-3293</u>	
17 INFORMANT <u>Mrs. Catherine A. Kaufmann</u>		Address <u>(Same)</u>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute Coronary Occlusion</u> DUE TO (b) <u>Coronary Artery Disease, Atherosclerotic</u> DUE TO (c) <u></u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work	20e PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)	20f (City or town) (County) (State)
21. I certify that (1) (this hospital) attended the deceased from <u>1965</u> to <u>12/12</u> , 19 <u>67</u> , that (1) <u>we</u> last saw the deceased alive on <u>12/12</u> , 19 <u>67</u> , and that death occurred at <u>10 A</u> M, from causes and on the date stated above.			
22a SIGNATURE <u>John G. Orth, M.D.</u>		22b DATE SIGNED <u>12/12/67</u>	
22c PHYSICIAN'S NAME (Type) <u>John G. Orth</u>		22d ADDRESS <u>8019 Philadelphia Rd.</u>	
23a BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b DATE THEREOF <u>12/16/67.</u>	23c NAME OF CEMETERY OR CREMATORY <u>Holy Cross Cemetery</u>	23d LOCATION (City or Town) (County) (State) <u>Baltimore, Md.</u>
24 FUNERAL DIRECTOR <u>Leonard J. Ruck, Inc Baltimore, Md.</u>		25a REC'D BY REGISTRAR DATE <u>DEC 15 1967</u>	
		25b REGISTRAR'S SIGNATURE <u>Charles Jones</u>	



1  
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

16571

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH 10563

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>MARYLAND</b> c. LENGTH OF STAY IN 1b <b>Baltimore</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Ridgeway Manor Nursing Home</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b> d. STREET ADDRESS <b>104 North Hilton Street</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First <b>Bessie</b> Middle <b>May</b> Last <b>Kaye</b>		4. DATE OF DEATH Month <b>December</b> Day <b>20</b> Year <b>1967</b>				
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 4, 1879</b>	9. AGE (In years last birthday) <b>88</b> yrs.	IF UNDER 1 YEAR Months <b>8</b> Days <b>10</b>	IF UNDER 24 HRS. Hours <b>10</b> Min. <b>00</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country)		12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME <b>Charles E. Jamison</b>			14. MOTHER'S MAIDEN NAME <b>Ellen M. Ferguson</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <b>216-46-5691</b>		17. INFORMANT <b>Elizabeth Sherman</b> Address <b>301 McMechen St.</b>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral hemorrhage</b> DUE TO (b) DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					INTERVAL BETWEEN ONSET AND DEATH <b>1 day</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>						
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>1 Nov, 1967</b> to <b>20 Dec, 1967</b> , that (I) (we) last saw the deceased alive on <b>20 Dec, 1967</b> and that death occurred at <b>11</b> M, from the causes and on the date stated above.						
22a. SIGNATURE <b>William B. Gorman</b> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>					22b. DATE SIGNED <b>21 Dec 67</b>	
22c. PHYSICIAN'S NAME (Type) <b>153X J. L. PHILLIPS JR. MD</b>					22d. ADDRESS <b>15331 Dulles Rd. from RD-2122</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>12/23/67</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Landon Park Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Baltimore, Md.</b>
24. FUNERAL DIRECTOR <b>Wm. J. Tiekert Sons North Pa.</b> ADDRESS <b>Baltimore, Md.</b>				25a. REC'D BY REGISTRAR <b>DEC 27 1967</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>



# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16572

## CERTIFICATE OF DEATH

10564

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Towson 21204</b>		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
c. LENGTH OF STAY IN 1b <b>4 mons 27 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>11214 York Road, Cockeysville, Md</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Dulaney Towson Nursing Home</b>		d. STREET ADDRESS <b>11214 York Road</b>	
3. NAME OF DECEASED (Type or print) <b>Dan Bosley Kelley</b>		4. DATE OF DEATH Month <b>December</b> Day <b>20</b> Year <b>1967</b>	
5 SEX <b>male</b>	6 COLOR OR RACE <b>white</b>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>12/19/1884</b>
9. AGE (in years lost birthday) <b>83 yrs</b>		IF UNDER 1 YEAR Months Days Hours Min. <b>12/19/1884</b>	
10a USAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>salesman-dis. Manager</b>		10b KIND OF BUSINESS OR INDUSTRY <b>Rumford Chemical</b>	
11 BIRTHPLACE (County & State, or foreign country) <b>Belfast, Maryland</b>		12 CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13 FATHER'S NAME <b>William H. Kelley</b>		14. MOTHER'S MAIDEN NAME <b>Annie Brooks</b>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO <b>037-01-1048A</b>	
17 INFORMANT <b>Dulaney Towson Nursing Home, 111 West Road</b>		Address <b>21204</b>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Chronic Pyelonephritis (Calculus) with Uremia</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)		INTERVAL BETWEEN ONSET AND DEATH <b>15 years +</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Bronchopneumonia</b>		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>1945</b> to <b>DEC. 20, 1967</b> , that (I) (we) saw the deceased alive on <b>DEC. 19, 1967</b> , and that death occurred at <b>1:40 P.M.</b> , from causes and on the date stated above.			
22a SIGNATURE <b>Robert W. Garis</b>		22b. DATE SIGNED <b>12/20/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>ROBERT W. GARIS, M.D.</b>		22d. ADDRESS <b>12 E. EAGER ST. BALTO., MD. 21202</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE THEREOF <b>Dec. 22, 1967</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Black Rock Cemetery</b>	23d. LOCATION (City or Town) (County) (State) <b>Baltimore Co., Maryland</b>
24 FUNERAL DIRECTOR <b>Wm. Cook-Brooks Towson, 1050 York Road Towson, Md. 21204</b>		25a REC'D BY REGISTRAR <b>DEC 21 1967</b>	
25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>			



TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
16573 CERTIFICATE OF DEATH 16565

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Pikesville 8, Md.</u> c. LENGTH OF STAY IN b <u>24 yrs</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>1708 Reisterstown Rd., Pikesville, Md.</u>		2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Pikesville 8, Md.</u> d. STREET ADDRESS <u>1708 Reisterstown Road</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Michael John Kelly</u> First Middle Last		4. DATE OF DEATH <u>Dec 14 1967</u> Month Day Year	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 14, 1894</u>
9. AGE (In years last birthday) <u>73 yrs.</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>	11. BIRTHPLACE (County & State, or foreign country) <u>Newburyport, Mass.</u>
10a. KIND OF BUSINESS OR INDUSTRY <u>U.S. Government</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Charles R. Kelly</u>		14. MOTHER'S MAIDEN NAME <u>Mary McQuade</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes give war or dates of service) <u>W.W.I</u>		16. SOCIAL SECURITY NO. <u>218-36-4708</u>	
17. INFORMANT <u>Mrs. Sarah Donlevy Kelly, 1708 Reisterstown Rd.</u>		Address <u>Pikesville 8, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Pulmonary emphysema, severe</u> DUE TO (b) <u>Severely</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 <u>12 Dec 1967</u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)		INTERVAL BETWEEN ONSET AND DEATH <u>Several years</u>	
21. I certify that (I) (the hospital) attended the deceased from <u>12 Dec 1967</u> to <u>14 Dec 1967</u> , that (I) (the hospital) last saw the deceased alive on <u>12 Dec 1967</u> , and that death occurred at <u>6:54 PM</u> , from the causes and on the date stated above.		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
22a. SIGNATURE <u>Paul H Royse</u> 22c. PHYSICIAN'S NAME (Type) <u>Paul H Royse</u>		22b. DATE SIGNED <u>Dec 14 1967</u> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS <u>1403 Foley La. Pikesville, Md.</u>	
23a. BURIAL CREMATION REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>Dec. 18, 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>St. Mary's Cemetery</u>	23d. LOCATION (City, town or county) (State) <u>Newburyport, Mass.</u>
24. FUNERAL DIRECTOR'S SIGNATURE <u>Frank A. Newell, Pikesville, Md.</u>		25a. REC'D BY REGISTRAR <u>DEC 18 1967</u> 25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
ISM 1/67

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
16574											
16566											
1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Mount Wilson</b> c. LENGTH OF STAY IN 1b <b>19 days</b>						2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Cecil</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Elkton</b>					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Mount Wilson State Hospital</b>						d. STREET ADDRESS <b>210 Friendship Rd</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <b>ELLIS</b> First <b>SAMUEL</b> Middle <b>KILMON</b> Last						4. DATE OF DEATH Month <b>12</b> Day <b>18</b> Year <b>1967</b>					
5. SEX <b>M</b>		6. COLOR OR RACE <b>W</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>2-9-1890</b>		9. AGE (In years last birthday) <b>77</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Lineman</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>ELECTRIC</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Columbia, Pa</b>				12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>SAMUEL KILMON</b>						14. MOTHER'S MAIDEN NAME <b>GEORGIA CROSLY</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>UNKNOWN</b>				16. SOCIAL SECURITY NO. <b>216-07-1810</b>		17. INFORMANT Address <b>Records, Mt. Wilson State Hospital</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Congestive Heart failure - Respiratory insufficiency</b> DUE TO (b) <b>Co2 Pulmonale, chronic</b> DUE TO (c) <b>Obstructive Emphysema, pulmonary</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>11-29</b> , 19 <b>67</b> , to <b>12-18</b> , 19 <b>67</b> , that (I) (we) lost saw the deceased alive on <b>12-18</b> 19 <b>67</b> , and that death occurred at <b>7:20</b> M, from causes on and on the date stated above.											
22a. SIGNATURE <b>W. Newcomer</b>						M.D. ATTENDING PHYS <input type="checkbox"/> MED AM DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED <b>12/18/67</b>			
22c. PHYSICIAN'S NAME (Type) <b>Wm. Newcomer, M.D., Superintendent</b>						22d. ADDRESS <b>Mount Wilson, Maryland</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>12/20/67</b>		23c. NAME OF CEMETERY OR CREMATORY <b>MT. ERIN</b>				23d. LOCATION (City or Town) (County) (State) <b>HAVER DEGRACE MD.</b>			
24. FUNERAL DIRECTOR <b>Roggin Funeral Home</b>						ADDRESS <b>259 ELKTON MAIN ST.</b>		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE <b>Johnas Judge</b>	
DATE <b>DEC 20 1967</b>											



CERTIFICATE OF DEATH

16575

15567

1 PLACE OF DEATH a. COUNTY <b>BALTIMORE</b>		2. USUAL RESIDENCE (Where deceased lived, if institution or Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>BALTIMORE</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>TOWSON</b>		c. LENGTH OF STAY IN IT <b>ESSEX</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>ST. JOSEPH HOSPITAL</b>		e. STREET ADDRESS <b>410 TORNER ROAD #21221</b>	
3 NAME OF DECEASED (Type or print) First Middle Last <b>CORNELIUS KEITH KING, SR.</b>		4 DATE OF DEATH Month Day Year <b>DECEMBER 6 19 67</b>	
5 SEX <b>MALE</b>	6 COLOR OR RACE <b>WHITE</b>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>DECEMBER 18, 1920</b>
9 AGE (in years last birthday) <b>46</b> yrs		10. IF UNDER 1 YEAR Months Days Hours Min.	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>SALESMAN</b>		11b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <b>BREVARD, NORTH CAROLINA</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>CARR W. KING</b>		14. MOTHER'S MAIDEN NAME <b>JULIA JONES</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>YES WW II</b>		16. SOCIAL SECURITY NO. <b>250-03-5250</b>	
17. INFORMANT <b>ANNE KING</b>		Address <b>410 TORNER RD.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinomatosis</b> DUE TO (b) <b>primary in pancreas</b> DUE TO (c) <b>primary in pancreas</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Pulmonary thrombo embolism</b>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>OCTOBER 20, 19 67</b> , to <b>DECEMBER 6 19 67</b> that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>DECEMBER 6 19 67</b> , and that death occurred at <b>4:00 P.M.</b> , from causes on and on the date stated above.			
22a. SIGNATURE <b>Reynaldo Orjuela-Gomez, M.D.</b>		22b. DATE SIGNED <b>12/6/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>Reynaldo Orjuela-Gomez, M.D.</b>		22d. ADDRESS <b>7620 York Rd., Towson, Md. 21204</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>12/9/67</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>PARKWOOD</b>		23d. LOCATION (City or Town) (County) (State) <b>BALTO. MD</b>	
24. FUNERAL DIRECTOR <b>J.B. CONNELLY SONS</b>		25a. REC'D BY REGISTRAR <b>300 MACE</b>	
25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>		DATE <b>DEC 8 1967</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by them, the director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, page 2, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

16576

16568

1 PLACE OF DEATH a COUNTY <b>Baltimore</b> b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Towson</b>		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a STATE <b>Maryland</b> b COUNTY <b>Baltimore</b>	
c LENGTH OF STAY IN 1b <b>0-1</b>		c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore 21234</b>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>ST. JOSEPH HOSPITAL</b>		d STREET ADDRESS <b>1709 Edgewood Rd.</b>	
3 NAME OF DECEASED (Type or print) First Middle Last <b>Elizabeth L. KING</b>		4 DATE OF DEATH Month Day Year <b>December 21, 1967</b>	
5 SEX <b>Female</b>	6 COLOR OR RACE <b>White</b>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 AGE (In years last birthday) yrs <b>61</b>
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Homemaker &amp; School Teacher</b>		10b KIND OF BUSINESS OR INDUSTRY	
11 BIRTHPLACE (State or foreign country) <b>Maryland</b>		12 CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13 FATHER'S NAME <b>Arthur A. Rencher</b>		14 MOTHER'S MAIDEN NAME <b>Helen Hibler</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16 SOCIAL SECURITY NO <b>219-36-5880</b>	
17 INFORMANT <b>Mr. Melvin T. King</b>		Address <b>1709 Edgewood Rd. 34</b>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Massive intra-cerebral hemorrhage</b> DUE TO (b) <b>Rupture of a Berry cerebral aneurysm.</b> DUE TO (c) (Condition, if any, which gave rise to immediate cause (a), stating the underlying cause lost)			INTERVAL BETWEEN ONSET AND DEATH
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State) <b>Baltimore, Md.</b>
21 I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Indetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Charles F. O'Donnell, M.D.</b>		22. DATE SIGNED <b>12/22/67</b>	
EXAMINER'S NAME (Type)		Address (Street, city, town or county)	
23a BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>	23b DATE THEREOF <b>12/24/67</b>	23c NAME OF CEMETERY OR CREMATORY <b>Moreland Memorial Park</b>	23d LOCATION (City or Town) (County) (State) <b>Baltimore, Md.</b>
24 FUNERAL DIRECTOR <b>J. F. Eline &amp; Sons</b>		25a RECD BY REGISTRAR <b>DEC 26 1967</b>	
ADDRESS <b>Reisterstown, Md.</b>		25b REGISTRAR'S SIGNATURE <b>Charles J. Jones</b>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16577										CERTIFICATE OF DEATH										15569									
1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND										2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>BALTIMORE</u>																			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BALTIMORE</u>					c. LENGTH OF STAY IN 1b <u>7 MRS</u>					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HERVILLER</u>																			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>St. Elizabeth's Hospital</u>										d. STREET ADDRESS <u>101 GORDON RD</u>										e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) <u>EMMA</u> First Middle Last										4. DATE OF DEATH <u>Dec</u> Month <u>7</u> Day <u>6</u> Year																			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Nov 11 1926</u>		9. AGE (In years last birthday) yrs <u>41</u>		IF UNDER 1 YEAR Months <u>0</u> Days <u>7</u>		IF UNDER 24 HRS Hours <u>0</u> Min <u>7</u>																	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>					10b. KIND OF BUSINESS OR INDUSTRY					11. BIRTHPLACE (County & State, or foreign country) <u>BALTIMORE MD</u>					12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>														
13. FATHER'S NAME <u>BERNARD HEFEMAN</u>										14. MOTHER'S MAIDEN NAME <u>EMELIA FINELSTEIN</u>																			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>					16. SOCIAL SECURITY NO <u>216-019178</u>					17. INFORMANT <u>HOSPICE RECORDS</u>					Address														
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute myocardial infarct</u> DUE TO (b) <u>Asen</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)										INTERVAL BETWEEN ONSET AND DEATH																			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTR BUT NOT CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of item 18)																								
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>					20a. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>					20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)					20f. (City or town) (County) (State)														
21. I certify that (I) (this hospital) attended the deceased from <u>12/7/67</u> to <u>12/7/67</u> , that (I) (we) last saw the deceased alive on <u>12/6/67</u> and that death occurred at <u>8:05 PM</u> from causes and on the date stated above.																													
22a. SIGNATURE <u>Robert J. Mahon</u>					M.D. ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS <input type="checkbox"/>					22b. DATE SIGNED <u>12/18/67</u>																			
22c. PHYSICIAN'S NAME (Type) <u>ROBERT J. MAHON, M.D.</u>					22d. ADDRESS <u>204 E. Joppa Road Towson, Md. 21204</u>																								
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>					23b. DATE THEREOF <u>DEC. 11, 1967</u>					23c. NAME OF CEMETERY OR CREMATORY <u>St. STEPHEN'S CEM.</u>					23d. LOCATION (City or Town) (County) (State) <u>BRADSHAW MARYLAND</u>														
24. FUNERAL DIRECTOR <u>RAYMOND L. CURRAN</u>					ADDRESS <u>1017 K. A. C. DR. Towson, Md. 21204</u>					25a. REC'D BY REGISTRAR <u>DEC 26 1967</u>					25b. REGISTRAR'S SIGNATURE <u>Charles Jones</u>														





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1 PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BALTIMORE</b> c. LENGTH OF STAY IN 1b <b>BALTIMORE</b>		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>BALTIMORE</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BALTIMORE</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>3524 LANGREHR ROAD, APT 1D, LIBERTY WEST</b>		d. STREET ADDRESS <b>LIBERTY WEST APTS. 3524 LANGREHR ROAD, APT. 1D</b>	
3 NAME OF DECEASED (Type or print) <b>FAVE</b>		4. DATE OF DEATH Month <b>DECEMBER</b> Day <b>13</b> Year <b>19 67</b>	
5 SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1-24-1890</b> 9 AGE (in years last birthday) <b>77</b> yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>AT HOME</b>	11 BIRTHPLACE (County & State, or foreign country) <b>BALTIMORE, MARYLAND</b>
13. FATHER'S NAME <b>MORRIS LIPSITZ</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO	
17. INFORMANT <b>MR. LOUIS KLAVERS, 3524 LANGREHR RD., APT. 1D</b>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Myocardial Infarction</b> DUE TO (b) <b>Coronary Artery Disease</b> DUE TO (c) <b>5 yrs.</b>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour 'o.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>10/16</b> , 1967, to <b>12/13</b> , 1967, that (I) (we) last saw the deceased alive on <b>12/6</b> , 1967, and that death occurred at <b>7:30 A</b> M, from causes and on the date stated above			
22a. SIGNATURE <b>Dr. Albert Himelfarb</b>		22b. DATE SIGNED <b>12/13/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>DR. ALBERT HIMELFARB</b>		22d. ADDRESS <b>3501 ST. PAUL STREET</b>	
23a. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE THEREOF <b>12-14-67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>BETH HAMEDROSH HAGODOL</b>	23d. LOCATION (City or Town) (County) (State) <b>ROSEDALE, MARYLAND</b>
24. FUNERAL DIRECTOR <b>SOL KLEVINSON &amp; BROS. INC., 6010 REISTERSTOWN RD.</b>		25a. REC'D BY REGISTRAR <b>Charles Judge</b>	
25b. REGISTRAR'S SIGNATURE		DATE <b>DEC 18 1967</b>	



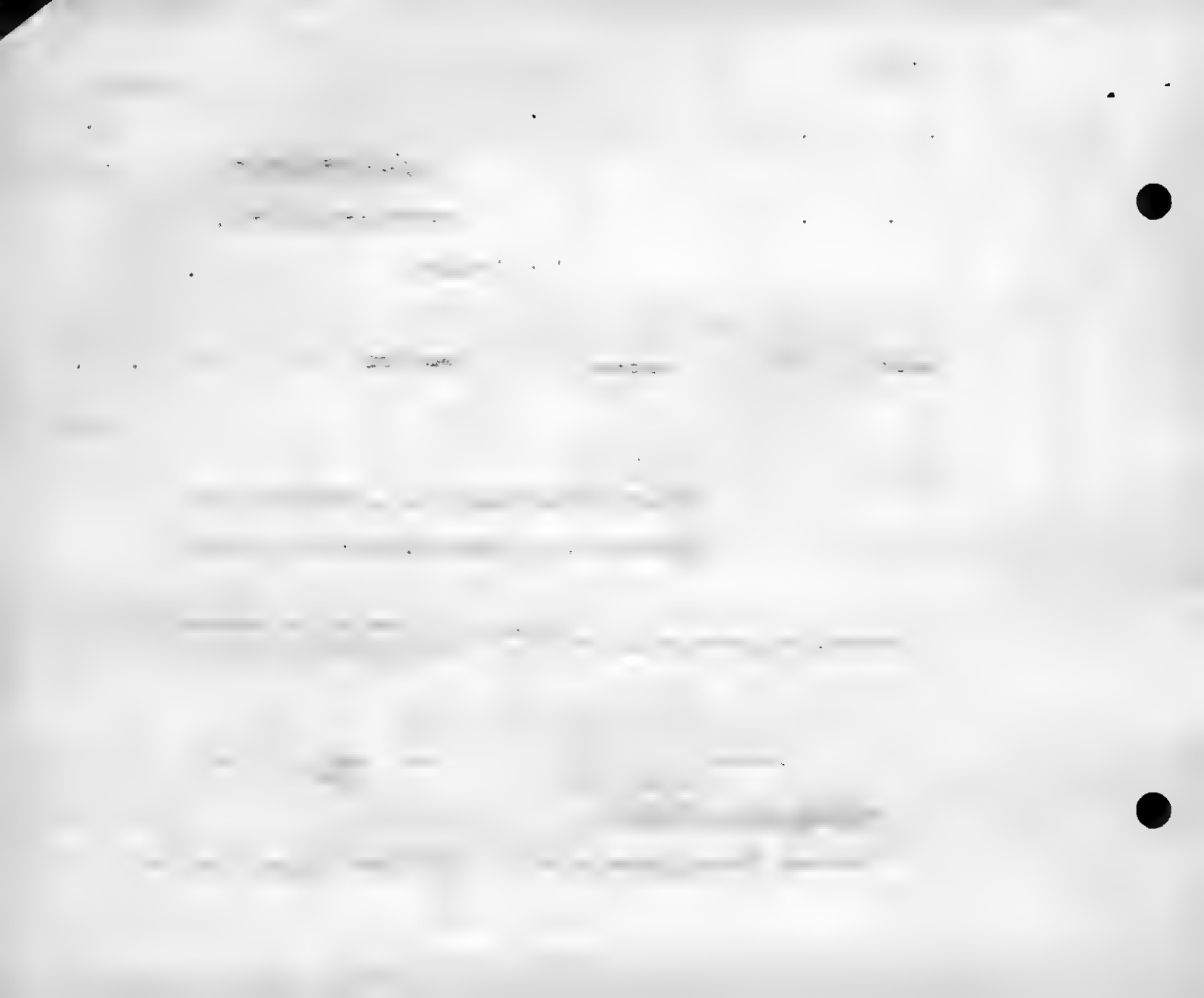
CERTIFICATE OF DEATH

16579

16571

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY <b>Baltimore, Md.</b> <b>Baltimore, MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived, if institution or Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Balto.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Randallstown</b>	
c. LENGTH OF STAY IN 1b		d. STREET ADDRESS <b>3711 Valley Hill Dr.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Balto. Cnty. General Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3 NAME OF DECEASED (Type or print) <b>Oscar, KLEIN</b>		4 DATE OF DEATH Month <b>Dec.</b> Day <b>6</b> Year <b>19 67</b>	
5 SEX <b>Male</b>	6 COLOR OR RACE <b>White</b>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>9/27/23</b>
9 AGE (In years last birthday) <b>44 yrs</b>		10 IF UNDER 1 YEAR Months <b>4</b> Days <b>4</b> Hours <b>4</b> Min <b>4</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Shoery</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Retail</b>	
11 BIRTHPLACE (County & State, or foreign country) <b>Balto. Md.</b>		12 CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Harry Klein</b>		14. MOTHER'S MAIDEN NAME <b>SARAH Gordon</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No.</b>		16. SOCIAL SECURITY NO. <b>218-18-3477</b>	
17. INFORMANT <b>Mrs. Marian Klein - 3711 Valley Hill Dr.</b>		Address <b>Randallstown</b>	
18. CAUSE OF DEATH (Enter only one cause per line, or (a), (b), and (c)) PART I: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>ACUTE MYOCARDIAL INFARCTION</b> DUE TO <b>HYPERTENSIVE CARDIOVASCULAR DISEASE</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>SECONDARY TO COMPLETE THYROIDECTOMY</b> (c) <b>FOR THYROID MALIGNANCY</b>		INTERVAL BETWEEN ONSET AND DEATH	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>SEVERE HYPOTHYROIDISM</b>			
19. WAS A T.O.P.S.Y. PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (the hospital) attended the deceased from <b>12-6-1967</b> to <b>12-6-1967</b> , that (I) (we) last saw the deceased alive on <b>12-6-1967</b> , and that death occurred at <b>6:30 PM</b> , from causes on and the date stated above.			
22a. SIGNATURE <b>Joseph Deckelbaum, M.D.</b>		22b. DATE SIGNED <b>12-6-67</b>	
22c. PHYSICIAN'S NAME (Type) <b>JOSEPH DECKELBAUM, M.D.</b>		22d. ADDRESS <b>3502 WEST ROGERS AVE. BALTO. 21215</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>12/7/67</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Liberty Park Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Randallstown Md.</b>	
24. FUNERAL DIRECTOR <b>Sal Lerman &amp; Bros Inc. 6010 Reisterstown Rd.</b>		25a. REC'D BY REGISTRAR <b>DEC 8 1967</b>	
		25b. REGISTRAR'S SIGNATURE <b>Charles Jones</b>	



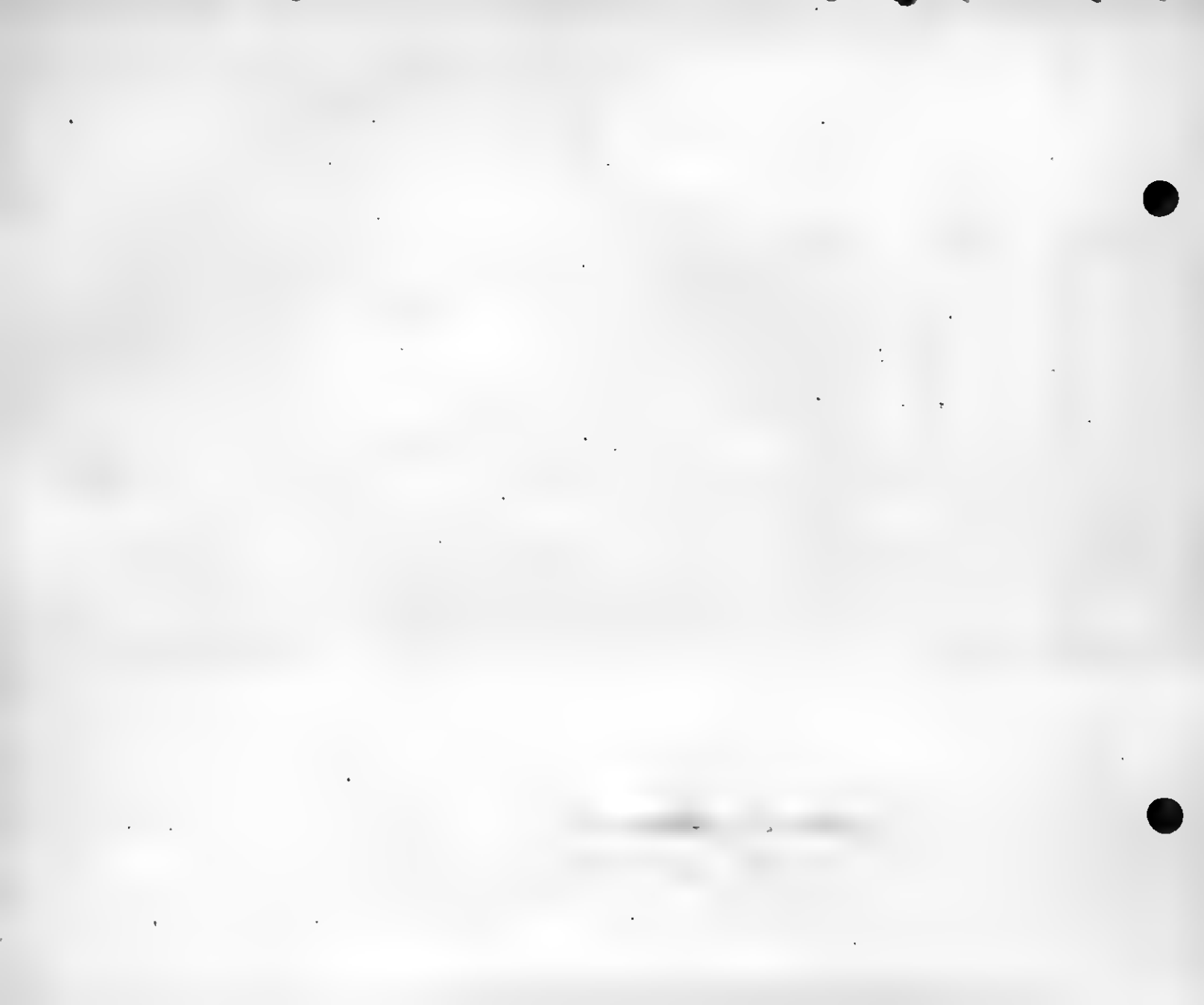
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
16530  
CERTIFICATE OF DEATH  
15572

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b> c. LENGTH OF STAY IN 1b <b>8 days</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Greater Baltimore Medical Center</b>		2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Balto.</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Towson</b> d. STREET ADDRESS <b>105 Shealy Avenue</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Edna Virginia Kling</b>		4. DATE OF DEATH Month Day Year <b>12 13 1967</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Cau.</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1/31/11</b>
9. AGE (In years last birthday) <b>57 50 yrs.</b>		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>George Kyger</b>		14. MOTHER'S MAIDEN NAME <b>unknown</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no none</b>		16. SOCIAL SECURITY NO. <b>229-14-6575</b>	
17. INFORMANT <b>Family records</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Subarachnoid hemorrhage</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Ruptured Berry aneurysm of Circle of Willis</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>12/6</b> , 19 <b>67</b> , to <b>12/13</b> , 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>12/13</b> , 19 <b>67</b> , and that death occurred at <b>9:45M</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>John E. Adams</b>		22b. DATE SIGNED <b>12/13/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>John E. Adams, M.D.</b>		22d. ADDRESS <b>6701 N. Charles Street</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>12/18/67</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Immanuel Church Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Glenora Md.</b>	
24. FUNERAL DIRECTOR <b>John Burns Sons</b>		25a. REC'D BY REGISTRAR <b>Lowson</b>	
25b. REGISTRAR'S SIGNATURE <b>William J. Judge</b>		DATE <b>DEC 18 1967</b>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16581

CERTIFICATE OF DEATH

15573

1 PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Towson</b>		c LENGTH OF STAY IN 1b <b>Baltimore</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>St. Joseph Hospital</b>		d STREET ADDRESS <b>10 W. Elm Avenue 21206</b>	
3 NAME OF DECEASED (Type or print) <b>GEORGE L. KLINK, JR.</b>		4 DATE OF DEATH Month <b>December 17</b> Day <b>19</b> Year <b>67</b>	
5 SEX <b>Male</b>	6 COLOR OR RACE <b>White</b>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>11-28-27</b>
9 AGE (in years last birthday) yrs <b>40</b>		10a USUA. OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Unemployed</b>	
10b KIND OF BUSINESS OR INDUSTRY		11 BIRTHPLACE (County & State, or foreign country) <b>Baltimore</b>	
12 CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>George L. Klink Sr.</b>	
14. MOTHER'S MAIDEN NAME <b>Bessie V. Moseman</b>		15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>	
16 SOCIAL SECURITY NO <b>220-24-2069</b>		17 INFORMANT Address <b>Sister - Margaret Pierpoint same</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <b>* 60X</b> IMMEDIATE CAUSE (a) <b>Uremia</b> DUE TO (b) <b>Diabetic Glomerulo-sclerosis</b> DUE TO (c) <b>Diabetes Mellitus</b>		INTERVAL BETWEEN ONSET AND DEATH	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e PLACE OF INJURY (Home, farm, factory, street, office bldg. etc)	20f (City or town) (County) (State)
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>12-15</b> , 19 <b>67</b> , to <b>12-17</b> , 1967, that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>12-17</b> , 1967, and that death occurred at <b>11:40 a.m.</b> from causes and on the date stated above			
22a SIGNATURE <b>Lawrence Misanik, M.D.</b>		22b. DATE SIGNED <b>12-17-67</b>	
22c PHYSICIAN'S NAME (Type) <b>Lawrence Misanik, M.D.</b>		22d ADDRESS <b>7620 York Road, Towson, Md. 21204</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>12-20-1967</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Loudon Park Cemetery</b>	23d. LOCATION (City or Town) (County) (State) <b>Baltimore Co. Md.</b>
24. FUNERAL DIRECTOR <b>Lessaun Funeral Home 7401 Belair Road</b>		25a. REC'D BY REGISTRAR DATE <b>DEC 22 1967</b>	
25b. REGISTRAR'S SIGNATURE <b>H. Charles Judge</b>			





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16582

CERTIFICATE OF DEATH

16574

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>		c. LENGTH OF STAY IN 1b <b>Days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore 21212</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>5470 Addington Road</b>				d. STREET ADDRESS <b>512 Dunkirk Road</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Walter Ray Knaube</b> First Middle Last				4. DATE OF DEATH <b>December 12, 1967</b> Month Day Year			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 2, 1895</b>		9. AGE (In years last birthday) <b>72 yrs.</b>	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Manager/Manager</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>RESTAURANT</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Penna.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A</b>	
13. FATHER'S NAME <b>Unknown</b>				14. MOTHER'S MAIDEN NAME <b>Unknown</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO <b>162-22-1334</b>		17. INFORMANT <b>Mrs. Pearl Knaube, Same as # 2</b> Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: <b>156.1 IMMEDIATE CAUSE (a) Carcinoma of liver</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) _____ DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH <b>2 years</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>March 12, 1956</b> , to <b>Dec 12, 1967</b> , that (I) (we) lost saw the deceased alive on <b>Dec 11, 1967</b> , and that death occurred at _____ M, from causes and on the date stated above.							
22a. SIGNATURE <b>Richard Gaff</b>				M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED <b>12/13/67</b>	
22c. PHYSICIAN'S NAME (Type)				22d. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>12-14-1967</b>		23c. NAME OF CEMETERY OR CREMATORY <b>St. John's Lutheran</b>		23d. LOCATION (City or Town) (County) (State) <b>Cumberland Co., Penna.</b>	
24. FUNERAL DIRECTOR <b>Wm. Cook-Brooks Towson,</b>				ADDRESS <b>1050 York Road Towson, Md. 21204</b>		25a. REC'D BY REGISTRAR <b>DEC 19 1967</b>	
				25b. REGISTRAR'S SIGNATURE <b>Richard Judge</b>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

16583

16575

1 PLACE OF DEATH a COUNTY <u>Baltimore</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institut on Residence before admission) a STATE <u>Md.</u> b COUNTY	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>		c LENGTH OF STAY IN 1b <u>Baltimore</u>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Shangri-La Nursing Home</u>		d STREET ADDRESS <u>766 Ramlay St.</u>	
3 NAME OF DECEASED (Type or print) <u>MATILDA</u> Koch		4 DATE OF DEATH Month <u>12</u> Day <u>11</u> Year <u>1967</u>	
5 SEX <u>F</u>	6 COLOR OR RACE <u>Wh</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>2/26/86</u>
9 AGE (In years lost birthday) <u>81</u> yrs.		10 IF UNDER 1 YEAR Months Days Hours Min	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b KIND OF BUSINESS OR INDUSTRY	
11 BIRTHPLACE (County & State, or foreign country) <u>Balto., Md.</u>		12 CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13 FATHER'S NAME <u>Ferdinand Koch</u>		14 MOTHER'S MAIDEN NAME <u>Katharine ----</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16 SOCIAL SECURITY NO.	
17 INFORMANT <u>Miss Rinnie Koch</u> <u>766 Ramsay St. - 212 30</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebral Arteriosclerosis</u> DUE TO (b) <u>Arteriosclerotic Cardio Vascular Disease</u> DUE TO (c) <u>Decane</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1B)	
20c TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.		20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)	
21 I certify that (I) (his hospital) attended the deceased from <u>Nov. 10, 1964</u> to <u>Dec 11, 1967</u> , that (I) ( <u>was</u> ) last saw the deceased alive on <u>Dec 11, 1967</u> , and that death occurred at <u>9:24 PM</u> , from causes and on the date stated above.			
22a SIGNATURE <u>Harry L. Knipp</u>		22b DATE SIGNED <u>12-12-67</u>	
22c PHYSICIAN'S NAME (Type) <u>Harry L. Knipp</u>		22d ADDRESS <u>4116 Edmondson Ave. Balt, Md 21229</u>	
23a BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b DATE THEREOF <u>12/15/67</u>	
23c NAME OF CEMETERY OR CREMATORY <u>Western Cemetery</u>		23d LOCATION (City or Town) (County) (State) <u>Baltimore, Md.</u>	
24 FUNERAL DIRECTOR <u>Witzke R. D. - 4161 Edmondson Av.</u>		25a REC'D BY REGISTRAR DATE <u>DEC 14 1967</u>	
25b REGISTRAR'S SIGNATURE <u>Charles J. J...</u>			



## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

16577

FOR STATE  
HEALTH DEPT.

16584

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>		
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore #22</b>		c LENGTH OF STAY IN 1b <b>9 Years</b>		c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore #22</b>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>38 Waterview Road (Dundalk)</b>			d STREET ADDRESS <b>38 Waterview Road (Dundalk)</b>		e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3 NAME OF DECEASED (Type or print) <b>Charles Joseph Kolper</b>			4 DATE OF DEATH Month <b>December</b> Day <b>17</b> Year <b>1967</b>		
5. SEX <b>Male</b>	6 COLOR OR RACE <b>White</b>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>Nov. 21, 1899</b>	9 AGE (In years last birthday) <b>68</b> yrs	F UNDER 1 YEAR Months Days Hours Min
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Superintendent (ret.)</b>		10b KIND OF BUSINESS OR INDUSTRY <b>Gibbs Packing Co.</b>		11 BIRTHPLACE (State or foreign country) <b>Rochester, N.Y.</b>	
12 CITIZEN OF WHAT COUNTRY? <b>USA</b>			13. FATHER'S NAME <b>John Kolper</b>		
14. MOTHER'S MAIDEN NAME <b>Anna (unknown)</b>			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No None</b>		
16. SOCIAL SECURITY NO <b>216-10-0974</b>			17. INFORMANT <b>Mrs. Julia K. Kolper (wife) Same as #2</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY <b>2043 Acute Leukemia</b> IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH <b>6 mos</b>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town)	(County)	(State)
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <b>Theodore C. Patterson</b>		M.D. <b>Theodore C. Patterson</b>		22. DATE SIGNED <b>12/19/67</b>	
EXAMINER'S NAME (Type) <b>Theodore C. Patterson</b>		M.D. <b>M.D.</b>		Address (Street, city, town, or county) <b>105 Main St. Dundalk, Md. 21222</b>	
23a BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>	23b DATE THEREOF <b>Dec. 20, 1967</b>	23c NAME OF CEMETERY OR CREMATORY <b>Gardens of Faith Cemetery Baltimore, Maryland</b>		23d LOCATION (City or Town) (County) (State)	
24. FUNERAL DIRECTOR <b>E. B. Fleming</b>		ADDRESS <b>Singleton Funeral Home Glen Burnie, Md.</b>		25a REC'D BY REGISTRAR <b>Charles Judge</b>	
25b REGISTRAR'S SIGNATURE		DATE <b>DEC 20 1967</b>			



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 9/60

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

16585

1. PLACE OF DEATH  
a. COUNTY **Baltimore** MARYLAND

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) **Bowleys Quarters**

c. LENGTH OF STAY IN b. **Box 26, Route 15**

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) **Box 26, Route 15**

2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)  
a. STATE **Md. 21220** b. COUNTY **Baltimore**

c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) **Bowleys Quarters**

d. STREET ADDRESS **96 (76 Middle Rd.)**

e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print)  
First **WILLIAM** Middle **KRAI** Last **SOR**

4. DATE OF DEATH  
Month **Dec.** Day **16** Year **1967**

5. SEX **male**

6. COLOR OR RACE **white**

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH **6/10/1904**

9. AGE (in years last birthday) **63** yrs.

IF UNDER 1 YEAR  
Months **63** Days **0**

IF UNDER 24 HRS  
Hours **0** Min. **0**

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) **Presser**

10b. KIND OF BUSINESS OR INDUSTRY **Modern Mfg.**

11. BIRTHPLACE (State or foreign country) **Baltimore, Md.**

12. CITIZEN OF WHAT COUNTRY? **Baltimore, Md.**

13. FATHER'S NAME **Fredrick Kraisser**

14. MOTHER'S MAIDEN NAME **Anna Shach**

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) **no**

16. SOCIAL SECURITY NO. **216-07-1344**

17. INFORMANT **Katherine Karas, friend, above**

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I. DEATH WAS CAUSED BY:  
IMMEDIATE CAUSE (a) **H-S-C-V-Disease**  
**4221** DUE TO  
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) **None**  
(c) **None**

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. (a) **None**

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) **None**

20c. TIME OF INJURY  
Hour **19** e.m. **19** p.m. **19**

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) **None**

20f. (City or town) **None** (County) **None** (State) **None**

21. I certify that I took charge of the remains described above, held an Autopsy ☐ Inspection ☒ Inquiry ☒ and in my opinion death resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER ☐

DEPUTY MEDICAL EXAMINER ☒

Address (Street, city, town, or county) **6800 MORNINGTON ROAD 21222**

DATE SIGNED **12-15-67**

22a. BURIAL, CREMATION, REMOVAL (Specify) **Burial**

22b. DATE THEREOF **12/19/67**

22c. NAME OF CEMETERY OR CREMATORY **Holy Redeemer Cemetery**

22d. LOCATION (City, town, or country) **Baltimore, Md.** (State) **Md.**

23. FUNERAL DIRECTOR  
**Schirunek Funeral Home, Inc.**  
**3331 Brehms Lane**

24a. REC'D BY REGISTRAR **DEC 21 1967**

24b. REGISTRAR'S SIGNATURE **Charles Judge**

MEDICAL CERTIFICATION





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
16586 10579											
1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>---</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)				c. LENGTH OF STAY IN 1b <u>33</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> <u>2124</u>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Greater Baltimore Medical Center</u>						d. STREET ADDRESS <u>3112 Cedarcroft Ave</u>					
3. NAME OF DECEASED (Type or print) First <u>Peter</u> Middle <u>(NMN)</u> Last <u>Kucik</u> Jr.						4. DATE OF DEATH Month <u>12</u> Day <u>5</u> Year <u>1967</u>					
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>11/24/1911</u>		9. AGE (In years last birthday) <u>56</u> yrs.		10. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Stationary Eng.</u>				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (County & State, or foreign country) <u>AUSTRIA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>George Kucik</u> <u>XXXXXXXXXXXX</u>						14. MOTHER'S MAIDEN NAME <u>Amelia</u> <u>XXXXXXXXXXXX</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NA</u> <u>NA</u>				16. SOCIAL SECURITY NO. <u>21P-01-89524</u>		17. <u>IRMAH</u> Address <u>Mrs. Anna Kucik- Same</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>cardio-vascular failure,</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Atherosclerotic heart disease, pneumonia</u> DUE TO (c) <u>Myocardial infarction</u>										INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>11/3</u> , 19 <u>67</u> , to <u>12/5</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>12/5</u> , 19 <u>67</u> , and that death occurred at <u>8 AM</u> , from the causes and on the date stated above.											
22a. SIGNATURE <u>F. Navidi</u>						22b. DATE SIGNED <u>12/5</u>					
22c. PHYSICIAN'S NAME (Type) <u>Dr. A. Renick</u>						22d. ADDRESS <u>Greater Balto. Medical Center</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>12/8/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Parkwood Cemetery</u>				23d. LOCATION (City, town or county) (State) <u>Baltimore Co, Maryland</u>			
24. FUNERAL DIRECTOR <u>Leonard J. Ruck Inc. 5305 Harford Rd. #</u>						25a. REC'D BY REGISTRAR <u>DEC 6 1967</u>		25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>			



1000000

1000000

1000000

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH					
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201					
16587		CERTIFICATE OF DEATH		16587	
1 PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Lutherville</b>		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Towson</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>College Manor Nursing Home</b>		d. STREET ADDRESS <b>Dulaney Valley Apts.</b>			
3 NAME OF DECEASED (Type or print) <b>Eva J. Kunkel</b>		4. DATE OF DEATH <b>12-2-1967</b>		19	
5 SEX <b>F</b>	6 COLOR OR RACE <b>Cauc</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>6-28-1875</b>	9 AGE (In years last birthday) <b>92</b> yrs	IF UNDER 1 YEAR Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY		11 BIRTHPLACE (County & State, or foreign country) <b>Baltimore, Md.</b>	
13 FATHER'S NAME <b>Gershom Johnson</b>		14. MOTHER'S MAIDEN NAME <b>Mary K. McCahn</b>		12 CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No.</b>		16. SOCIAL SECURITY NO. <b>216 09-0567D</b>		17. INFORMANT Address <b>Mrs Helen Chittick, Towson, Md. 21204</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral thrombosis</b> DUE TO <b>Arteriosclerotic cardiovascular disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) <b>Arteriosclerotic cardiovascular disease</b> DUE TO (c) <b>Arteriosclerotic cardiovascular disease</b>		INTERVAL BETWEEN ONSET AND DEATH <b>1 week</b>			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		20g. (City or town) (County) (State)		20h. (City or town) (County) (State)	
21. I certify that (I) <del>(this hospital)</del> attended the deceased from <b>January 1964</b> to <b>December 1967</b> , that (I) (we) last saw the deceased alive on <b>December 30 1967</b> , and that death occurred at <b>5:40 P.M.</b> from causes and on the date stated above.		22a. SIGNATURE <b>A. Allen Spier</b>		22b. DATE SIGNED <b>12/4/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>A. Allen Spier</b>		22d. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL, ETC. <b>Burial</b>		23b. DATE THEREOF <b>12-5-67</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Loudon Park</b>	
23d. LOCATION (City or town) (County) (State) <b>Baltimore, Md.</b>		23e. ADDRESS <b>Wm. Cook-Brooks Towson, Towson, Md. 21204</b>		23f. REC'D BY REGISTRAR <b>DEC 7 1967</b>	
23g. REGISTRAR'S SIGNATURE <b>William Cook-Brooks</b>		23h. REGISTRAR'S SIGNATURE			



16588

## CERTIFICATE OF DEATH

16588

1. PLACE OF DEATH a. COUNTY <u>Balto.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution- Residence before admission) a. STATE <u>md.</u> b. COUNTY <u>---</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Balto.</u>	
c. LENGTH OF STAY IN 1b <u>1 day</u>		d. STREET ADDRESS <u>348 Broadmoor Rd</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Greater Balto. Medical Center</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Tina H. Kucina</u>		4. DATE OF DEATH Month <u>12</u> Day <u>24</u> Year <u>1967</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>CAU.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4-7-82</u>
9. AGE (In years last birthday) <u>85</u> yrs.		10. IF UNDER 1 YEAR Months <u>---</u> Days <u>---</u> Hours <u>---</u> Min <u>---</u>	
11. BIRTHPLACE (County & State or foreign country) <u>Austria</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Alois NMW Hanzlik</u>		14. MOTHER'S MAIDEN NAME <u>Mariem Chagek</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>N/A</u>		16. SOCIAL SECURITY NO <u>unknown</u>	
17. INFORMANT <u>Pt's. chart</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>MYOCARDIAL FAILURE</u> DUE TO (b) <u>Arteriosclerotic cardiovascular disease</u> DUE TO (c) <u>---</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>DEHYDRATION &amp; ELECTROLYTE IMBALANCE</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>---</u> p.m. <u>---</u> 19 <u>---</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>12/23</u> , 19 <u>67</u> , to <u>12/24</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>12/24</u> 19 <u>67</u> , and that death occurred at <u>3:25 AM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Deek A Bruce</u>		22b. DATE SIGNED <u>12/24/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>DEAN ELL A. B KUCIN</u>		22d. ADDRESS <u>G. B. A. C</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>12/28/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Oaklawn</u>	23d. LOCATION (City or Town) (County) (State) <u>Baltimore County, Md.</u>
24. FUNERAL DIRECTOR <u>H.W. Jenkins &amp; Sons Co. 4905 York Rd. Balto. 12, Md.</u>		25a. REC'D BY REGISTRAR DATE <u>DEC 27 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>		25c. REGISTRAR'S NAME <u>[Signature]</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



CERTIFICATE OF DEATH

16589

16589

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Reisterstown</b> c. LENGTH OF STAY IN 1b <b>28 years</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>23 Hanover Road</b>		2. USUAL RESIDENCE (Where deceased lived, if institutional; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Reisterstown</b> d. STREET ADDRESS <b>23 Hanover Road</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Annie Silex Landau</b> First Middle Last		4. DATE OF DEATH <b>December 28 19 67</b> Month Day Year	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>January 3, 1895</b> Year
9. AGE (In years last birthday) <b>72</b> Months Days Hours Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Stettin, Germany</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Heinrich Silex</b>		14. MOTHER'S MAIDEN NAME <b>Anna Hennig</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>220-54-3013</b>	
17. INFORMANT <b>Dr. S. Walter Landau</b>		Address <b>23 Hanover Rd., Reisterstown, Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Acute coronary occlusion</b> DUE TO (b) <b>Arteriosclerotic cardio-vascular disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <b>at once</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>INTERVAL BETWEEN ONSET AND DEATH</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>Mar 16, 1962</b> to <b>Dec. 28, 1967</b> that (I) (we) last saw the deceased alive on <b>Dec. 28, 1967</b> and that death occurred at <b>4:15 P.M.</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>S. Walter Landau</b>		22b. DATE <b>12-27-67</b>	
22c. PHYSICIAN'S NAME (Type) <b>S. Walter Landau</b>		22d. ADDRESS <b>23 Hanover Rd., Reisterstown</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>Dec. 30, 1967</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Evergreen Mem. Gardens Finksburg, Maryland</b>	23d. LOCATION (City, town or county) (State) <b>Md.</b>
24. FUNERAL DIRECTOR'S SIGNATURE <b>H. J. Schardt</b>		25a. REC'D BY REGISTRAR <b>JAN</b> 25b. REGISTRAR'S SIGNATURE <b>ge</b>	

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.





16590

## CERTIFICATE OF DEATH

583

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Essex</u>				c. LENGTH OF STAY IN 1b <u>Baltimore</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Ivy Hall Nursing Home</u>				d. STREET ADDRESS <u>1420 Shore Road</u>			
3. NAME OF DECEASED (Type or print) First <u>Katherine</u> Middle <u>E.</u> Last <u>Long</u>				4. DATE OF DEATH Month <u>December</u> Day <u>31</u> Year <u>1967</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 7, 1887</u>	9. AGE (In years last birthday) <u>80</u> yrs	IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> M.in. <u>  </u>	11. BIRTHPLACE (County & State, or foreign country) <u>USA</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>			10b. KIND OF BUSINESS OR INDUSTRY		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		
13. FATHER'S NAME <u>Gustav Walter</u>				14. MOTHER'S MAIDEN NAME <u>Marie ?</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>			16. SOCIAL SECURITY NO		17. INFORMANT <u>Mr. Frederick Boerschel</u> Address <u>700 Meridene Dr.</u>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Chronic Myocardial Failure</u> DUE TO <u>Arteriosclerotic Cardiovascular Disease &amp; Hypertension</u> DUE TO <u>  </u> (c) <u>  </u>							INTERVAL BETWEEN ONSET AND DEATH <u>2 yrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>  </u> p.m. <u>19</u>			20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Dec 10</u> , 19 <u>67</u> , to <u>Dec 30</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>Dec 30</u> , 19 <u>67</u> , and that death occurred at <u>104</u> M, from causes and on the date stated above.							
22a. SIGNATURE <u>W. W. W. W. W.</u>				22b. DATE SIGNED <u>12/31/67</u>	22c. PHYSICIAN'S NAME (Type) <u>Balto 21237</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>1/4/68</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Loudon Park Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Baltimore, Md.</u>	
24. FUNERAL DIRECTOR <u>Leonard J. Ruck, Inc. Balto. Md. 21214</u>				25a. RECD BY REGISTRAR DATE <u>JAN 2 1968</u>		25b. REGISTRAR'S SIGNATURE <u>John J. Judge</u>	



10. 11. 11.

11. 11. 11.

12. 11. 11.

13. 11. 11.

14.

15. 11. 11. 16. 11. 11. 17. 11. 11. 18. 11. 11. 19. 11. 11. 20. 11. 11.

21. 11. 11. 22. 11. 11. 23. 11. 11. 24. 11. 11. 25. 11. 11. 26. 11. 11. 27. 11. 11. 28. 11. 11. 29. 11. 11. 30. 11. 11.

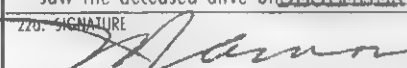

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

16591

16584

|   |                                  |  |  |
|---|----------------------------------|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY<br><b>BALTIMORE</b><br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>TOWSON</b><br>c. LENGTH OF STAY IN Tb<br><b>Baltimore</b><br>d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>ST. JOSEPH HOSPITAL</b>      |                                  | 2. USUAL RESIDENCE (Where deceased lived, if institution- Residence before admission)<br>a. STATE<br><b>MARYLAND</b><br>b. COUNTY<br><b>BALTIMORE</b><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Baltimore</b><br>d. STREET ADDRESS<br><b>3203 JOPPA ROAD #21234</b><br>e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 3. NAME OF DECEASED<br>(Type or print)<br>First Middle Last<br><b>MARTHA EUGENIA LANG</b>   |                                  | 4. DATE OF DEATH<br>Month Day Year<br><b>DECEMBER 27 1967</b>  |  |
| 5. SEX<br><b>FEMALE</b>   | 6. COLOR OR RACE<br><b>WHITE</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>  | 8. DATE OF BIRTH<br><b>APRIL 20, 1899</b>                              |
| 9. AGE (In years last birthday)<br><b>68 yrs</b>  |                                  | 10. IF UNDER 1 YEAR<br>Months Days Hours Min<br><b>27 19 67</b>  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>HOMELAKER</b>   |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>BALTIMORE COUNTY, MD.</b>  |  |
| 11. BIRTHPLACE (County & State, or foreign country)<br><b>U.S.A.</b>  |                                  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  |
| 13. FATHER'S NAME<br><b>Wilfred H. Fuller</b>   |                                  | 14. MOTHER'S MAIDEN NAME<br><b>Rosie L. Dent</b>   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) (If yes give war or dates of service)<br><b>No</b>   |                                  | 16. SOCIAL SECURITY NO.<br><b>215-07-0535</b>  |  |
| 17. INFORMANT<br><b>Mr. Howard Fuller</b>   |                                  | Address<br><b>(Same)</b>   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <b>MYOCARDIAL INFARCTION</b><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>DIABETES MELLITUS</b><br>DUE TO<br>(c) |                                  |  | INTERVAL BETWEEN ONSET AND DEATH                                       |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)  |                                  |  |  |
| 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |                                  |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)  |                                  | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)   |  |
| 20c. TIME OF INJURY<br>Hour a.m. Month, Day, Year<br>p.m. <b>19</b>   |                                  | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Not While <input type="checkbox"/><br>at work at work   | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) |
| 20f. (City or town) (County) (State)  |                                  |  |  |
| 21. I certify that (I) (this hospital) attended the deceased from <b>DECEMBER 27, 1967</b> , to <b>DECEMBER 27 19 67</b> that (I) (we) last saw the deceased alive on <b>DECEMBER 27 19 67</b> , and that death occurred at <b>11:10 PM</b> from causes and on the date stated above.                                     |                                  |  |  |
| 22a. SIGNATURE<br>   |                                  | 22b. DATE SIGNED<br><b>DECEMBER 27, 1967</b>   |  |
| 22c. PHYSICIAN'S NAME (Type)<br><b>ISMAEL JAMORA, M. D.</b>   |                                  | 22d. ADDRESS<br><b>7620 YORK ROAD TOWSON, MARYLAND</b>   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |                                  | 23b. DATE THEREOF<br><b>12/30/67.</b>  |  |
| 23c. NAME OF CEMETERY OR CREMATORY<br><b>Hiss Methodist Cemetery</b>  |                                  | 23d. LOCATION (City or Town) (County) (State)<br><b>Baltimore, Md.</b>   |  |
| 24. FUNERAL DIRECTOR<br><b>Leonard J. Ruck, Inc. Balto. Md. 21214</b>   |                                  | 25a. REC'D BY REGISTRAR<br><b>DEC 28 1967</b>  |  |
| 25b. REGISTRAR'S SIGNATURE<br>   |                                  |  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: This law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



16592

CERTIFICATE OF DEATH

16585

|  |                                 |   |   |
|--|---------------------------------|---|---|
| 1 PLACE OF DEATH<br>a. COUNTY <b>BALTIMORE</b><br>MARYLAND   |                                 | 2 USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)<br>a. STATE <b>MARYLAND</b><br>b. COUNTY <b>BALTIMORE</b>              |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>TOWSON</b>  |                                 | c. LENGTH OF STAY IN 1b<br><b>TOWSON</b>  |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>149 STEVENSON LANE</b>  |                                 | d. STREET ADDRESS<br><b>149 STEVENSON LANE</b>  |   |
| 3 NAME OF DECEASED<br>(Type or print)<br><b>WILLIAM E LEUTNER</b>  |                                 | 4 DATE OF DEATH<br><b>DECEMBER 19, 1967</b>   |   |
| 5 SEX<br><b>MALE</b>   | 6 COLOR OR RACE<br><b>WHITE</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | 8. DATE OF BIRTH<br><b>SEPT. 17, 1898</b> |
| 9 AGE (In years last birthday)<br><b>69</b> yrs.   |                                 | 10. IF UNDER 1 YEAR<br>Months Days Hours Min  |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>RETIRED</b>  |                                 | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>CLERK</b>   |   |
| 11 BIRTHPLACE (County & State, or foreign country)<br><b>BALTIMORE, MARYLAND</b>   |                                 | 12 CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |   |
| 13 FATHER'S NAME<br><b>HENRY LEUTNER</b>   |                                 | 14 MOTHER'S MAIDEN NAME<br><b>ELIZABETH HERION</b>  |   |
| 15 WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) (If yes give war or dates of service)<br><b>NO</b>   |                                 | 16. SOCIAL SECURITY NO<br><b>216-07-1460</b>  |   |
| 17. INFORMANT<br><b>A MRS. ELEANOR JOHNSON</b>   |                                 | Address<br><b>SAME</b>  |   |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY:<br><b>4500</b><br>IMMEDIATE CAUSE (a) <b>Acute Cardiac Failure</b><br>DUE TO<br>(b) <b>Arteriosclerosis</b><br>DUE TO<br>(c)   |                                 | INTERVAL BETWEEN ONSET AND DEATH  |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |                                 |   |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |                                 | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)  |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m. <b>19</b>   |                                 | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Not While <input type="checkbox"/><br>at work at work  |   |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |                                 | 20f. (City or town) (County) (State)  |   |
| 21. I certify that (I) (this hospital) attended the deceased from <b>June 20, 1960</b> , to <b>Dec. 19, 1967</b> , that (I) <del>was</del> last saw the deceased alive on <b>Dec. 19, 1967</b> , and that death occurred at <b>4:45</b> M, from causes and on the date stated above. |                                 |   |   |
| 22a. SIGNATURE<br><b>Lawrence C. Post</b>  |                                 | 22b. DATE SIGNED<br><b>12/20/67</b>   |   |
| 22c. PHYSICIAN'S NAME (Type)<br><b>DR. LAWRENCE C. POST</b>  |                                 | 22d. ADDRESS<br><b>6805 YORK RD. BALTIMORE, MD.</b>   |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>   |                                 | 23b. DATE THEREOF<br><b>12-20-67</b>  |   |
| 23c. NAME OF CEMETERY OR CREMATORY<br><b>DULANEY VALLEY</b>  |                                 | 23d. LOCATION (City or Town) (County) (State)<br><b>TIMONIUM, MARYLAND</b>  |   |
| 24. FUNERAL DIRECTOR<br><b>MITCHELL WIEDEFELD HOME, INC.</b><br><b>6500 YORK ROAD BALTIMORE, MD. 21212</b>   |                                 | 25a. REC'D BY REGISTRAR<br>DATE <b>12/20/67</b>   |   |
| 25b. REGISTRAR'S SIGNATURE   |                                 |   |   |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (pages 1) and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

16593

16586

FOR STATE HEALTH DEPT.

|   |                                 |   |   |
|---|---------------------------------|---|---|
| 1. PLACE OF DEATH<br>a COUNTY <b>Baltimore</b> MARYLAND   |                                 | 2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)<br>a STATE <b>Maryland</b> b COUNTY <b>16586</b>   |   |
| b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Woodlawn</b>  |                                 | c LENGTH OF STAY IN It<br><b>Woodlawn</b>   |   |
| d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>3410 JoAnn Drive D.O.A.</b>   |                                 | e STREET ADDRESS<br><b>3410 JoAnn Drive</b>   |   |
| 3 NAME OF DECEASED (Type or print)<br><b>HAROLD A. LEV</b>  |                                 | 4 DATE OF DEATH<br>Month <b>December</b> Day <b>3</b> Year <b>19 67</b>   |   |
| 5. SEX<br><b>Male</b>   | 6 COLOR OR RACE<br><b>White</b> | 7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>   | 8 DATE OF BIRTH<br><b>JUNE 26, 1928</b> |
| 9 AGE (In years last birthday)<br><b>39</b> yrs.  |                                 | 10 IF UNDER 1 YEAR<br>Months <b>3</b> Days <b>19</b> Hours <b>67</b> Min  |   |
| 11b USUAL OCCUPATION (Give kind of work done during most of work-nights, even if retired)<br><b>ATTORNEY</b>  |                                 | 11b KIND OF BUSINESS OR INDUSTRY<br><b>AT LAW</b>   |   |
| 11 BIRTHPLACE (State or foreign country)<br><b>BALTIMORE, MARYLAND</b>  |                                 | 12 CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |   |
| 13 FATHER'S NAME<br><b>CARL LEV</b>   |                                 | 14 MOTHER'S MAIDEN NAME<br><b>GUSSIE BUTENSKY</b>   |   |
| 15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><b>NO</b>   |                                 | 16 SOC. A. SECURITY NO.   |   |
| 17 INFORMANT<br><b>MRS. PHYLLIS LEV, 3410 JOANN DRIVE #21207</b>  |                                 | Address   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Gunshot wound of the head</b><br>DUE TO (b)<br>DUE TO (c)<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.  |                                 | INTERVAL BETWEEN ONSET AND DEATH  |   |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |                                 | 19 WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |   |
| 20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |                                 | 20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)<br><b>Subject shot himself</b>  |   |
| 20c TIME OF INJURY Month, Day, Year<br>Hour a.m. <b>Pro. 6 12 3 1967</b>  |                                 | 20d INJURY ON <input type="checkbox"/> HEAD <input checked="" type="checkbox"/> WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT HOME <input checked="" type="checkbox"/> |   |
| 20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)<br><b>Home</b>  |                                 | 20f (City or town) (County) (State)<br><b>Woodlawn Balto. Md.</b>   |   |
| 21 I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |                                 |   |   |
| ACTUAL SIGNATURE<br><b>Edward F. Wilson</b> M.D.  |                                 | CHIEF MEDICAL EXAMINER <input type="checkbox"/>   |   |
| EXAMINER'S NAME (Type)<br><b>Edward F. Wilson, M.D.</b>   |                                 | ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>  |   |
| 23a BURIAL, CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>   |                                 | 23b DATE THEREOF<br><b>12-4-67</b>  |   |
| 23c NAME OF CEMETERY OR CREMATORY<br><b>BETH EL MEMORIAL PARK</b>   |                                 | 23d LOCATION (City or town) (County) (State)<br><b>BALTIMORE, MARYLAND</b>  |   |
| 24 FUNERAL DIRECTOR<br><b>SOL LEVINSON &amp; BROS. INC., 6010 REISTERSTOWN ROAD</b>   |                                 | 25a RECD BY REGISTRAR<br><b>DEC 5 1967</b>  |   |
| 25b REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>   |                                 | 22. DATE SIGNED<br><b>December 3, 1967</b>  |   |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Pages 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
6M 1/67

SOL LEVINSON & BROS. INC., 6010 REISTERSTOWN ROAD

DATE DEC 5 1967

1967

Charles Judge





CERTIFICATE OF DEATH

16594

15587

|  |  |   |   |
|--|--|---|---|
| 1 PLACE OF DEATH<br>a. COUNTY <u>Baltimore</u><br>MARYLAND   |  | 2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission)<br>a. STATE <u>MD.</u><br>b. COUNTY                                    |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Towson</u>  |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Baltimore</u>  |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><u>Chesapeake Manor Nursing Home</u>   |  | d. STREET ADDRESS<br><u>9850 Harford Road</u>   |   |
| 3 NAME OF DECEASED<br>(Type or print) <u>Robert</u> First <u>Lisle</u> Middle <u>Lisle</u> Last  |  | 4. DATE OF DEATH<br>Month <u>December</u> Day <u>25</u> Year <u>1967</u>  |   |
| 5. SEX<br><u>Male</u>  | 6 COLOR OR RACE<br><u>White</u>  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8 DATE OF BIRTH<br><u>Jul. 23, 1877</u>   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life; even if retired)<br><u>Retired from Eastern...</u>  |  | 10b. KIND OF BUSINESS OR INDUSTRY   | 9 AGE (In years last birthday) yrs. <u>89</u><br>IF UNDER 1 YEAR<br>Months <u>1</u> Days <u>25</u> Hours <u>0</u> Min <u>0</u><br>IF UNDER 24 HRS |
| 11 BIRTHPLACE (County & State, or foreign country)<br><u>Reisterstown</u>  |  | 12 CITIZEN OF WHAT COUNTRY?<br><u>U.S.</u>  |   |
| 13 FATHER'S NAME<br><u>John D. Lisle</u>   |  | 14. MOTHER'S MAIDEN NAME<br><u>Annie Crawford</u>   |   |
| 15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><u>No</u>  |  | 16 SOCIAL SECURITY NO<br><u>216-45-8108</u>   |   |
| 17 INFORMANT<br><u>Mrs. Emmitt Power</u>   |  | Address<br><u>9850 Harford Rd. Balto. Md.</u>   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I DEATH WAS CAUSED BY:<br><u>154X</u> IMMEDIATE CAUSE (a) <u>Carcinoma Rectum</u><br>DUE TO <u>metastasis</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <u>Generalized Cachexia.</u><br>(c) <u>Generalized Cachexia.</u> |  | INTERVAL BETWEEN ONSET AND DEATH<br><u>1 yr. + 4 mos.</u>   |   |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)  |  |   |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)   |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. <u>19</u> p.m. <u>19</u>   | 20d INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)<br><u>Sept</u>  | 20f (City or town) (County) (State)<br><u>Dec</u>   |
| 21. I certify that (I) (this hospital) attended the deceased from <u>Sept</u> , 19 <u>67</u> , to <u>Dec</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>Dec 20</u> , 19 <u>67</u> , and that death occurred at <u>11</u> M., from causes and on the date stated above.   |  |   |   |
| 22a. SIGNATURE<br><u>F.T. KASIK JR</u>   |  | 22b. DATE SIGNED<br><u>12/26/67</u>   |   |
| 22c. PHYSICIAN'S NAME (Type)<br><u>F.T. KASIK JR</u>   |  | 22d. ADDRESS<br><u>9005 HARFORD RD</u>  |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Buried</u>   | 23b. DATE THEREOF<br><u>Dec. 28, 67</u>  | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Lutheran Cemetery</u>  | 23d. LOCATION (City or Town) (County) (State)<br><u>Reisterstown, Md.</u>   |
| 24 FUNERAL DIRECTOR<br><u>J. F. Eline &amp; Sons</u>   |  | 25a. REC'D BY REGISTRAR<br><u>DEC 28 1967</u>   |   |
| ADDRESS<br><u>Reisterstown, Md.</u>  |  | 25b. REGISTRAR'S SIGNATURE<br><u>Charles</u>  |   |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and, in any event, within 72 hours after death.



# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
6M 1/67

16595

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

16588

|  |   |   |  |
|--|---|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Baltimore</u> MARYLAND   |   | 2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission)<br>a. STATE <u>Pennsylvania</u> b. COUNTY <u>Baldwin</u>              |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>To son</u>  |   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Lockesville</u>  |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><u>St. Joseph's Hospital</u>   |   | d. STREET ADDRESS<br><u>10313 Calverton Circle</u>  |  |
| 3. NAME OF DECEASED (Type or print)<br><u>Hellie</u>   |   | 4. DATE OF DEATH<br>Month <u>December</u> Day <u>22</u> Year <u>1967</u>  |  |
| 5. SEX<br><u>Female</u>  | 6. COLOR OR RACE<br><u>White</u>          | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><u>April 12, 1906</u>  |
| 9. AGE (In years last birthday) yrs <u>61</u>  |   | 10. IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>housewife</u>  |   | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>own home</u>  |  |
| 11. BIRTHPLACE (State or foreign country)<br><u>Pennsylvania</u>   |   | 12. CITIZEN OF WHAT COUNTRY?<br><u>U.S.</u>   |  |
| 13. FATHER'S NAME<br><u>Thomas J. Russell</u>  |   | 14. MOTHER'S MAIDEN NAME<br><u>Elizabeth Sutton</u>   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><u>no</u>   |   | 16. SOCIAL SECURITY NO<br><u>None</u>   |  |
| 17. INFORMANT<br><u>Family records</u>   |   | Address   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u><br>DUE TO (b) <u>Hypertensive Inter-arteriole</u><br>DUE TO (c) <u>Cardiac Rupture</u><br>DUE TO (d) <u>10/26</u>   |   | INTERVAL BETWEEN ONSET AND DEATH<br><u>Sudden</u>   |  |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |   | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>   |   | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item B)   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour <u>  </u> m. <u>  </u> p.m. <u>  </u> 19 <u>  </u>  |   | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/> |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |   | 20f. (City or town) (County) (State)  |  |
| 21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from <u>Natural causes</u> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |   |   |  |
| ACTUAL SIGNATURE<br><u>Charles F. O'Donnell</u> M.D.   |   | 22. DATE SIGNED<br><u>12/22/67</u>  |  |
| EXAMINER'S NAME (Type)<br><u>Charles F. O'Donnell, M.D.</u>  |   | Address (Street, city, town, or county)   |  |
| 23a. BURIAL, CREMATION, REMOVAL <input checked="" type="checkbox"/>  | 23b. DATE THEREOF<br><u>Dec. 26, 1967</u> | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Woodlawn Center</u>  | 23d. LOCATION (City or town) (County) (State)<br><u>Titusville, Pennsylvania</u> |
| 24. FUNERAL DIRECTOR<br><u>John Wynn's Sons, To son, Maryland</u>  |   | 25a. REC'D BY REGISTRAR<br>DA <u>DEC 27 1967</u>  |  |
| 25b. REGISTRAR'S SIGNATURE<br><u>[Signature]</u>   |   |   |  |



16596

Item #2b,c &amp; d Film #21201/17

## CERTIFICATE OF DEATH

16589

|   |                                |   |                                   |
|---|--------------------------------|---|-----------------------------------|
| 1 PLACE OF DEATH<br>a. COUNTY<br><b>Baltimore</b><br>MARYLAND   |                                | 2 USUAL RESIDENCE (Where deceased lived, if institution Res dence before admission)<br>a. STATE<br><b>Maryland</b><br>b. COUNTY<br><b>Balto.</b>            |                                   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Rural - Towson</b>   |                                | c. LENGTH OF STAY IN 1b<br><b>21234</b>   |                                   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>Greater Baltimore Medical Center</b>   |                                | d. STREET ADDRESS<br><b>2902 Berwick Avenue</b>   |                                   |
| 3. NAME OF DECEASED<br>(Type or print)<br>First Middle Last<br><b>Clarence Edward Lohran</b>  |                                | 4. DATE OF DEATH<br>Month Day Year<br><b>12 7 19 67</b>   |                                   |
| 5 SEX<br><b>M</b>   | 6. COLOR OR RACE<br><b>Cau</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>5/5/04</b> |
| 9. AGE (In years lost birthday)<br><b>63</b> yrs  |                                | IF UNDER 1 YEAR<br>Months Days Hours Min<br><b>19 67</b>  |                                   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired)<br><b>Retired Accountant</b>   |                                | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>General Electric Co. Hungary</b>  |                                   |
| 11 BIRTHPLACE (County & State, or foreign country)<br><b>USA</b>  |                                | 12 CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |                                   |
| 13. FATHER'S NAME<br><b>Peter Lohran</b>  |                                | 14. MOTHER'S MAIDEN NAME<br><b>Marie Buocz</b>  |                                   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><b>No</b>  |                                | 16. SOCIAL SECURITY NO<br><b>215-09-8723</b>  |                                   |
| 17. INFORMANT<br><b>Mr. Vincent M. Lohran</b>   |                                | Address<br><b>134 N. Luzerne Ave</b>  |                                   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <b>Cardiorespiratory failure</b><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) <b>Carcinoma of lung</b><br>DUE TO<br>(c) |                                |   |                                   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |                                |   |                                   |
| 19. WAS A JTOPSY PERFORMED?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |                                | INTERVAL BETWEEN ONSET AND DEATH  |                                   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                                | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)   |                                   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m. <b>19</b>  |                                | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work  |                                   |
| 20e. PLACE OF INJURY (home, farm, factory, street, office bldg., etc.)  |                                | 20f. (City or town) (County) (State)  |                                   |
| 21. I certify that (I) (this hospital) attended the deceased from <b>Dec. 2</b> , 19 <b>67</b> , to <b>Dec. 7, 1967</b> , that (I) (we) last saw the deceased alive on <b>Dec. 6</b> , 19 <b>67</b> , and that death occurred at <b>7:30 a.m.</b> , from causes and on the date stated above.                                 |                                |   |                                   |
| 22a. SIGNATURE<br><b>John E. Adams</b>  |                                | 22b. DATE SIGNED<br><b>12/7/67</b>  |                                   |
| 22c. PHYSICIAN'S NAME (Type)<br><b>John E. Adams, M.D.</b>  |                                | 22d. ADDRESS<br><b>6701 N. Charles Street</b>   |                                   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |                                | 23b. DATE THEREOF<br><b>12/11/67</b>  |                                   |
| 23c. NAME OF CEMETERY OR CREMATORY<br><b>Holy Redeemer Cemetery</b>   |                                | 23d. LOCATION (City or Town) (County) (State)<br><b>Baltimore, Maryland</b>   |                                   |
| 24. FUNERAL DIRECTOR<br><b>John A. Moran, Inc. 3000 E. Baltimore St.</b>  |                                | 25a. REC'D BY REGISTRAR<br><b>DEC 11 1967</b>   |                                   |
| 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>  |                                |   |                                   |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

|   |   |   |   |
|---|---|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>BALTO</b>   |   | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <b>MD.</b> b. COUNTY <b>BALTO.</b>                            |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>ESSEX</b>  |   | c. LENGTH OF STAY IN 1b   |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>701 MACE AVE</b>   |   | d. STREET ADDRESS<br><b>701 MACE AVE</b>  |   |
| e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   |   |   |
| 3. NAME OF DECEASED (Type or print) <b>FRANK WILLIAM LOTZ</b>   |   | 4. DATE OF DEATH<br>Month <b>12</b> Day <b>7</b> Year <b>1967</b>   |   |
| 5. SEX<br><b>M</b>  | 6. COLOR OR RACE<br><b>W</b>  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>     | 8. DATE OF BIRTH<br><b>NOV. 9, 1896</b>                           |
| 9. AGE (In years last birthday)<br><b>71</b> yrs.   |   | IF UNDER 1 YEAR: Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/><br>IF UNDER 24 HRS. |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>CLERK</b>   |   | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>COUNTY</b>  |   |
| 11. BIRTHPLACE (County & State, or foreign country)<br><b>MD.</b>   |   | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |   |
| 13. FATHER'S NAME<br><b>HENRY LOTZ</b>  |   | 14. MOTHER'S MAIDEN NAME<br><b>MARGARET MILLER</b>  |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>UNK</b>  |   | 16. SOCIAL SECURITY NO.<br><b>212-07-6153</b>   |   |
| 17. INFORMANT<br><b>ELIZABETH LOTZ</b>  |   | Address<br><b>701 MACE</b>  |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Coronary occlusion</b><br>T & U<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO (b) <b>arteriosclerotic Cardiovascular disease</b><br>DUE TO (c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) |   |   | INTERVAL BETWEEN ONSET AND DEATH<br><b>Sudden</b><br><b>2 yrs</b> |
| 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   |   |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m. <b>19</b>  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  | 20f. (City or town) (County) (State)                              |
| 21. I certify that (I) (this hospital) attended the deceased from <b>Jan 1, 1967</b> to <b>12-6, 1967</b> , that (I) (we) last saw the deceased alive on <b>12-6, 1967</b> , and that death occurred at <b>5A</b> M, from the causes and on the date stated above.  |   |   |   |
| 22a. SIGNATURE<br><b>EM. BAUMGARDNER</b>  |   | 22b. DATE SIGNED<br><b>12-7-67</b>  |   |
| 22c. PHYSICIAN'S NAME (Type)<br><b>EM. BAUMGARDNER</b>  |   | 22d. ADDRESS<br><b>8552 PHILA. RP.</b>  |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>  | 23b. DATE THEREOF<br><b>12/9/67</b>   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>PARKWOOD CEM</b>   | 23d. LOCATION (City, town or county) (State)<br><b>BALTO. MD.</b> |
| 24. FUNERAL DIRECTOR<br><b>J.G. CONNELLY SONS</b>   |   | 25a. REC'D BY REGISTRAR<br><b>DEC 8 1967</b>  |   |
| ADDRESS<br><b>300 MACE</b>  |   | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>  |   |





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

| MARYLAND STATE DEPARTMENT OF HEALTH<br>DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |   |   |  |
|--|---|---|--|
| 16593<br>CERTIFICATE OF DEATH<br>16594   |   |   |  |
| 1 PLACE OF DEATH<br>a. COUNTY <b>BALTIMORE</b><br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FORT HOWARD</b>  |   | 2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)<br>a. STATE <b>MARYLAND</b><br>b. COUNTY <b>MARYLAND</b><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>ROCKVILLE</b> |  |
| c. LENGTH OF STAY IN 1b <b>108 Days</b>  |   | d. STREET ADDRESS <b>12311 BRAXFIELD COURT</b>  |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>VETERANS ADMINISTRATION HOSPITAL</b>   |   | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |
| 3. NAME OF DECEASED<br>(Type or print) <b>First Middle Last</b><br><b>NAPOLEON LOVELY</b>  |   | 4. DATE OF DEATH<br>Month <b>DECEMBER 2,</b> Day <b>19</b> Year <b>67</b>   |  |
| 5. SEX <b>MALE</b>   | 6. COLOR OR RACE <b>WHITE</b>   | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>   | 8. DATE OF BIRTH <b>9 15 07</b>  |
| 9. AGE (In years last birthday) <b>60</b> yrs.   |   | 10. IF UNDER 1 YEAR<br>Months <b>19</b> Days <b>67</b> Hours <b>07</b> Min <b>00</b>  |  |
| 11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>CLERGYMAN</b>   |   | 11b. KIND OF BUSINESS OR INDUSTRY <b>CLERGYMAN</b>  |  |
| 12. BIRTHPLACE (County & State, or foreign country) <b>NORTH KINGSTON, RHODE ISLAND U.S.A.</b>   |   | 13. C. TIZEN OF WHAT COUNTRY? <b>U.S.A.</b>   |  |
| 13. FATHER'S NAME <b>JOSEPH LOVELY</b>   |   | 14. MOTHER'S MAIDEN NAME <b>ANN WIGLESWORTH</b>   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of service) <b>YES WW-11</b>  |   | 16. SOCIAL SECURITY NO. <b>440 42 5756</b>  |  |
| 17. INFORMANT <b>CLIN. REC., VAH, FORT HOWARD, MARYLAND</b>  |   | Address   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>PNEUMONIA, ASPIRATION</b><br>DUE TO (b) <b>CHRONIC BRAIN SYNDROME</b><br>Conditions if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <b>CHRONIC BRAIN SYNDROME</b> |   | INTERVAL BETWEEN ONSET AND DEATH<br><b>DAYS</b><br><b>MONTHS</b>  |  |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)  |   | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |   | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II at item 18)  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour <b>01</b> m <b>19</b> pm  | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work | 20e. PLACE OF INJURY (Home, farm, factory, street office bldg., etc.)   | 20f. (City or town) (County) (State)   |
| 21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>August 16, 19 67</b> to <b>Dec. 2, 1967</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>Dec. 2, 19 67</b> , and that death occurred <b>12:15a</b> AM, from causes and on the date stated above.   |   |   |  |
| 22a. SIGNATURE    |   | 22b. DATE SIGNED <b>12 2 67</b>   |  |
| 22c. PHYSICIAN'S NAME (Type) <b>JORGE A. FABARA, M. D.</b>   |   | 22d. ADDRESS <b>VET. ADM. HOSP., FT. HOWARD, MD.</b>  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>  | 23b. DATE THEREOF <b>12/5/67</b>  | 23c. NAME OF CEMETERY OR CREMATORY <b>ELM GROVE CEMETERY</b>  | 23d. LOCATION (City or Town) (County) (State) <b>NO. KINGSTON, RHODE ISLAND</b>                                  |
| 24. FUNERAL DIRECTOR <b>John J. Duda, Dundalk, Md.</b>   |   | 25a. REC'D BY REGISTRAR <b>GEO. C. CRANSTON WICKFORD, R. I.</b>   | 25b. REGISTRAR'S SIGNATURE  |

102

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## CERTIFICATE OF DEATH

16599

16592

|  |   |   |   |
|--|---|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>BALTIMORE</b> MARYLAND   |   | 2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)<br>a. STATE <b>MARYLAND</b> b. COUNTY <b>HARFORD</b>                   |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>FORT HOWARD</b>   |   | c. LENGTH OF STAY IN 1b<br><b>53 DAYS</b>   |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>VETERANS ADMINISTRATION HOSPITAL</b>  |   | d. STREET ADDRESS<br><b>329 MC CANN STREET</b>  |   |
| 3. NAME OF DECEASED (Type or print)<br>First <b>JOHN</b> Middle <b>GEORGE</b> Last <b>LOWE, JR.</b>  |   | 4. DATE OF DEATH<br>Month <b>DECEMBER</b> Day <b>18</b> Year <b>1967</b>  |   |
| 5. SEX<br><b>MALE</b>  | 6. COLOR OR RACE<br><b>WHITE</b>          | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>JULY 6, 1915</b>                                   |
| 9. AGE (In years last birthday)<br><b>52 yrs.</b>  |   | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>LABORER</b>  |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>LABORER</b>  |   | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>EDGEWOOD ARSENAL</b>  |   |
| 11. BIRTHPLACE (County & State, or foreign country)<br><b>STREET, MARYLAND</b>   |   | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |   |
| 13. FATHER'S NAME<br><b>JOHN/LOWE, SR.</b>   |   | 14. MOTHER'S MAIDEN NAME<br><b>AGNAS A. MARTIN</b>  |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><b>YES WW II</b>  |   | 16. SOCIAL SECURITY NO.<br><b>215 14 53 88</b>  |   |
| 17. INFORMANT<br><b>CLIN. RECORDS, VA HOSPITAL, FT HOWARD, MD.</b>   |   | Address   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>TUBERCULOUS MENINGITIS</b><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>MILITARY TUBERCULOSIS</b><br>DUE TO<br>(c) |   |   |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br><b>BRONCHOGENIC CARCINOMA WITH ADRENAL METASTASIS AND BRONCHOPNEUMONIA</b>  |   |   |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |   | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)  |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour <b>a.m.</b> <b>19</b>   |   | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>   |   |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |   | 20f. (City or town) (County) (State)  |   |
| 21. I certify that (1) (this hospital) attended the deceased from <b>10/26/67</b> , 19__, to <b>12/18/67</b> , 19__, that (2) (we) last saw the deceased alive on <b>12/18/67</b> , 19__, and that death occurred at <b>3:00 PM</b> from causes and on the date stated above.  |   |   |   |
| 22a. SIGNATURE<br><i>John D. Talbert</i>   |   | 22b. DATE SIGNED<br><b>12/19/67</b>   |   |
| 22c. PHYSICIAN'S NAME (Type)<br><b>JOHN D. TALBERT, M. D.</b>  |   | 22d. ADDRESS<br><b>VAH FORT HOWARD, MARYLAND</b>  |   |
| 23a. BURIAL CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>  | 23b. DATE THEREOF<br><b>Dec. 21, 1967</b> | 23c. NAME OF CEMETERY OR CREMATORY<br><b>BEL AIR MEMORIAL GARDENS</b>   | 23d. LOCATION (City or town) (County) (State)<br><b>BEL AIR, MARYLAND</b> |
| 24. FUNERAL DIRECTOR<br><b>HOWARD K.</b>   |   | 25a. REC'D BY REGISTRAR<br><b>MC COMAS FUNERAL HOME</b><br>DATE <b>DEC 21 1967</b>  |   |
|  |   | 25b. REGISTRAR'S SIGNATURE<br><i>Charles Judgen</i>   |   |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.


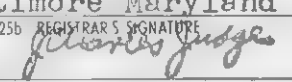
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

| MARYLAND STATE DEPARTMENT OF HEALTH  |  |                                     |  |  |  |   |  |  |  |  |  |
|--|--|-------------------------------------|--|--|--|---|--|--|--|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |                                     |  |  |  |   |  |  |  |  |  |
| CERTIFICATE OF DEATH   |  |                                     |  |  |  |   |  |  |  |  |  |
| 16593  |  |                                     |  |  |  |   |  |  |  |  |  |
| 1 PLACE OF DEATH<br>a. COUNTY <b>Baltimore</b> MARYLAND  |  |                                     |  |  |  | 2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY      |  |  |  |  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Catonsville</b>   |  |                                     |  | c. LENGTH OF STAY IN 1b<br><b>30yr7mth20dys</b>  |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Baltimore</b>                            |  |  |  |  |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>SPRING GROVE STATE HOSPITAL</b>   |  |                                     |  |  |  | d. STREET ADDRESS<br><b>3913 East Pratt Street</b>  |  |  |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>           |  |
| 3 NAME OF DECEASED<br>(Type or print)<br><b>Anna</b> First Middle Last   |  |                                     |  |  |  | 4 DATE OF DEATH<br><b>December 8 19 67</b> Month Day Year   |  |  |  |  |  |
| 5. SEX<br><b>female</b>  |  | 6. COLOR OR RACE<br><b>white</b>    |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8 DATE OF BIRTH<br><b>July 27, 1907</b>   |  | 9 AGE (In years and months)<br><b>60</b> yrs.  |  | IF UNDER 1 YEAR<br>Months Days Hours Min   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>housewife</b>  |  |                                     |  | 10b. KIND OF BUSINESS OR INDUSTRY  |  | 11 BIRTHPLACE (County & State, or foreign country)<br><b>Italy</b>  |  |  |  | 12 CITIZEN OF WHAT COUNTRY?<br><b>Italy</b> ✓  |  |
| 13. FATHER'S NAME<br><b>John Frasco</b>  |  |                                     |  |  |  | 14. MOTHER'S MAIDEN NAME<br><b>Josephine Attina</b>   |  |  |  |  |  |
| 15 WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) (If yes give war or dates of service)<br><b>NO</b>   |  |                                     |  | 16. SOCIAL SECURITY NO.<br><b>NONE</b>   |  | 17 INFORMANT<br><b>Records: SPRING GROVE STATE HOSPITAL</b> Address   |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Myocardial Infarction</b><br><b>4201</b> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(b) <b>Arteriosclerotic, Cardiovascular Ht. Dis.</b> 20 yrs.<br>DUE TO<br>(c) <b>Arteriosclerosis, Generalized, Senile</b> 20 yrs. |  |                                     |  |  |  |   |  |  |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>acute</b>   |  |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>230/100</b><br><b>Diabetes Mellitus (20yrs.), Obesity (300 lbs.), Hypertension</b>   |  |                                     |  |  |  |   |  |  |  | 19 WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |                                     |  | 20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)   |  |   |  |  |  |  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m. <b>19</b>   |  |                                     |  | 20d INJURY OCCURRED<br>While <input type="checkbox"/> Not While <input type="checkbox"/><br>at work at work  |  | 20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |  | 20f (City or town) (County) (State)  |  |  |  |
| 21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>April 1, 1967</b> , to <b>Dec. 8, 1967</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>Dec. 8, 1967</b> , and that death occurred at <b>8</b> M, from causes and on the date stated above.  |  |                                     |  |  |  |   |  |  |  |  |  |
| 22a SIGNATURE<br>   |  |                                     |  |  |  | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> |  | 22b DATE SIGNED<br><b>12-8-67</b>  |  |  |  |
| 22c. PHYSICIAN'S NAME (Type)<br><b>Anthony J. Young, M.D.</b>  |  |                                     |  |  |  | 22d ADDRESS <b>SPRING GROVE STATE HOSPITAL<br/>Baltimore, Maryland 21228</b>  |  |  |  |  |  |
| 23a BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |  | 23b DATE THEREOF<br><b>12/11/67</b> |  | 23c NAME OF CEMETERY OR CREMATORY<br><b>Oak Lawn Cemetery</b>  |  |   |  | 23d. LOCATION (City or Town) (County) (State)<br><b>Baltimore Maryland</b>   |  |  |  |
| 24 FUNERAL DIRECTOR<br><b>HENRY SANDER &amp; SONS INC.</b><br><b>BALTIMORE MARYLAND 21213</b>  |  |                                     |  |  |  | 25a. REC'D BY REGISTRAR<br><b>DEC 12 1967</b>   |  | 25b REGISTRAR'S SIGNATURE<br> |  |  |  |



VR A15 (4)  
20M 1/65





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

| MARYLAND STATE DEPARTMENT OF HEALTH  |  |  |   |   |  |  |   |   |  |
|--|--|--|---|---|--|--|---|---|--|
| DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND   |  |  |   |   |  |  |   |   |  |
| CERTIFICATE OF DEATH   |  |  |   |   |  |  |   |   |  |
| 16602 1595   |  |  |   |   |  |  |   |   |  |
| 1. PLACE OF DEATH<br>a. COUNTY <b>Baltimore</b> <b>MARYLAND</b>  |  |  |   |   | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> |  |   |   |  |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)<br><b>Rural - Towson</b>  |  |  |   | c. LENGTH OF STAY IN 1b<br><b>1 day</b>   |  | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)<br><b>Towson</b>  |   |   |  |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)<br><b>Greater Baltimore Medical Center</b>  |  |  |   |   | d. STREET ADDRESS<br><b>32 Sunvale Road</b>  |  |   | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 3. NAME OF DECEASED<br>(Type or print)<br>First <b>Kathryn</b> Middle <b>Elizabeth</b> Last <b>Manley</b>  |  |  | 4. DATE OF DEATH<br>Month <b>12</b> Day <b>6</b> Year <b>1967</b> |   |  |  |   |   |  |
| 5. SEX<br><b>Female</b>  |  | 6. COLOR OR RACE<br><b>White</b>             |   | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><b>April 8, 1896</b>   |   | 9. AGE (In years last birthday) <b>71</b> yrs. IF UNDER 1 YEAR Months Days Hours Min.             |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>housewife</b>  |  |  |   | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Jun Home</b>  |  | 11. BIRTHPLACE (County & State, or foreign country)<br><b>Illinois</b>   |   | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  |
| 13. FATHER'S NAME<br><b>Patrick L. Golden</b>  |  |  |   |   | 14. MOTHER'S MAIDEN NAME<br><b>Kathryn Sheedy</b>  |  |   |   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><b>No</b>   |  |  | 16. SOCIAL SECURITY NO.<br><b>None</b>                            |   | 17. INFORMANT<br><b>Family records</b>   |  | Address   |   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Malignant hypertension with uremia</b><br><b>772A</b> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Malignant nephrosclerosis</b><br>DUE TO (c) <b>Hypertensive cardiovascular disease</b> |  |  |   |   |  |  |   | INTERVAL BETWEEN ONSET AND DEATH  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)   |  |  |   |   |  |  |   | 19. WAS AUTOPSY PERFORMED?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |  |   |   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m. <b>19</b>   |  |  |   | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>   |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |   | 20f. (City or town) (County) (State)  |  |
| 21. I certify that (I) (this hospital) attended the deceased from <b>12/5</b> , 19 <b>67</b> , to <b>12/6</b> , 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>12/6</b> , 19 <b>67</b> , and that death occurred at <b>5:25M</b> , from the causes and on the date stated above.   |  |  |   |   |  |  |   |   |  |
| 22a. SIGNATURE<br><b>John E. Adams</b>   |  |  |   |   |  | am<br>M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> |   | 22b. DATE SIGNED<br><b>12/6/67</b>  |  |
| 22c. PHYSICIAN'S NAME (Type)<br><b>John E. Adams, M.D.</b>   |  |  |   |   |  | 22d. ADDRESS<br><b>6701 N. Charles Street</b>  |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>burial</b>   |  | 23b. DATE THEREOF<br><b>December 9, 1967</b> |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Julaney Valley Cemetery</b>  |  |  | 23d. LOCATION (City, town or county) (State)<br><b>Cockeysville, Maryland</b> |   |  |
| 24. FUNERAL DIRECTOR<br><b>John J. Burns Sons</b>  |  |  |   |   |  | ADDRESS<br><b>Towson Md.</b>   |   | 25a. REC'D BY REGISTRAR<br><b>DEC 11 1967</b>   |  |
|  |  |  |   |   |  | 25b. REGISTRAR'S SIGNATURE<br><b>J. Charles Judge</b>  |   |   |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1  
2

# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16603

## CERTIFICATE OF DEATH

15596

|  |                                  |   |  |  |   |
|--|----------------------------------|---|--|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY<br><b>Baltimore</b><br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Towson</b>  |                                  | c. LENGTH OF STAY IN 1b<br><b>1101 Longbrook Rd.</b>  |  | 2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission)<br>a. STATE<br><b>Maryland</b><br>b. COUNTY<br><b>Lutherville, 21093</b> |   |
| 3. NAME OF DECEASED (Type or print)<br>First Middle Last<br><b>Edgar Flavius Martin</b>  |                                  | 4. DATE OF DEATH<br>Month Day Year<br><b>December 21 1967</b>   |  | 5. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |   |
| 6. SEX<br><b>Male</b>  | 7. COLOR OR RACE<br><b>White</b> | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. AGE (In years last birthday)<br><b>66 yrs.</b>                      |  | 10. IF UNDER 1 YEAR<br>Months Days Hours Min  |
| 11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>retired (Exec. Sec.)</b>   |                                  | 11b. KIND OF BUSINESS OR INDUSTRY<br><b>INDUSTRY</b>  |  | 12. BIRTHPLACE (County & State, or foreign country)<br><b>Mississippi</b>  |   |
| 13. FATHER'S NAME<br><b>Lesley L. Martin</b>   |                                  | 14. MOTHER'S MAIDEN NAME<br><b>Ella Ward</b>  |  | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><b>no none</b>                                      |   |
| 16. SOCIAL SECURITY NO.<br><b>no</b>   |                                  | 17. INFORMANT<br><b>Family records</b>  |  | Address  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiac arrhythmia</b><br>DUE TO<br>(b) <b>Myocardial infarction</b><br>DUE TO<br>(c) <b>Coronary arteriosclerosis</b>                 |                                  |   |  |  | INTERVAL BETWEEN ONSET AND DEATH  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)   |                                  |   |  |  | 19. WAS AUTOPSY PERFORMED?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)   |  |  |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m. 19  |                                  | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Not While <input type="checkbox"/><br>at work at work  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State)   |   |
| 21. I certify that (this hospital) attended the deceased from <b>Dec. 16, 1967</b> , to <b>Dec. 21, 1967</b> , that (it) (we) last saw the deceased alive on <b>Dec. 21, 1967</b> , and that death occurred at <b>12:55 AM</b> , from causes and on the date stated above. |                                  |   |  |  |   |
| 22a. SIGNATURE<br><b>Ines Cilliani</b>   |                                  | 22b. DATE SIGNED<br><b>12/21/67</b>   |  | 22c. PHYSICIAN'S NAME (Type) <b>Ines Cilliani, M.D.</b>  |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |                                  | 23b. DATE THEREOF<br><b>Dec. 23, 1967</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Westwood Grove Cemetery</b>   |   |
| 23d. LOCATION (City or town) (County) (State)<br><b>Towson, Md.</b>  |                                  | 23e. REC'D BY REGISTRAR<br><b>DEC 26 1967</b>   |  | 23f. REGISTRAR'S SIGNATURE<br><b>Charles J. [Signature]</b>  |   |
| 24. FUNERAL DIRECTOR<br><b>John Burns' Sons, Towson, Maryland</b>  |                                  | 25. ADDRESS<br><b>7620 York Rd., Towson, Md. 21204</b>  |  |  |   |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of this certificate is to be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

|   |                              |  |                                      |
|---|------------------------------|--|--------------------------------------|
| 1. PLACE OF DEATH<br>a. COUNTY<br><b>Baltimore Co.</b>  |                              | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)<br>a. STATE<br><b>Maryland</b><br>b. COUNTY<br><b>Baltimore</b><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Hydes</b><br>d. STREET ADDRESS<br><b>Patterson Rd.</b> |                                      |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Hydes</b>  |                              | c. LENGTH OF STAY IN 1b  |                                      |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)  |                              | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                                      |
| 3. NAME OF DECEASED<br>(Type or print)<br>First Middle Last<br><b>Clara W. Masland</b>  |                              | 4. DATE OF DEATH<br>Month Day Year<br><b>December 14 1967</b>  |                                      |
| 5. SEX<br><b>F</b>  | 6. COLOR OR RACE<br><b>W</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>  | 8. DATE OF BIRTH<br><b>8/30/1895</b> |
| 9. AGE (In years last birthday)<br><b>72</b> yrs.   |                              | 10. IF UNDER 1 YEAR<br>Months Days<br><b>19 67</b>   |                                      |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Teacher</b>   |                              | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Musician</b>   |                                      |
| 11. BIRTHPLACE (County & State, or foreign country)<br><b>Boston, Mass. Y</b>   |                              | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |                                      |
| 13. FATHER'S NAME<br><b>Obidiah Firth Wells</b>   |                              | 14. MOTHER'S MAIDEN NAME<br><b>Helen Deeds</b>   |                                      |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><b>No</b>  |                              | 16. SOCIAL SECURITY NO.<br><b>525-26-3389A</b>   |                                      |
| 17. INFORMANT<br><b>Mr. Samuel Masland</b>  |                              | Address<br><b>Patterson Rd Hydes, Md.</b>  |                                      |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Malignant lymphoma</b><br>DUE TO (b) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <b>Rheumatoid arthritis</b><br>DUE TO (d) _____<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. (a) _____<br>19. WAS AUTOPSY PERFORMED?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                              |  |                                      |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                              |  |                                      |
| 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)  |                              | 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a.m. p.m.<br><b>19</b>   |                                      |
| 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>   |                              | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |                                      |
| 20f. (City or town)   |                              | (County) (State)   |                                      |
| 21. I certify that (I) (this hospital) attended the deceased from <b>January 6, 1967</b> to <b>December 14, 1967</b> , that (I) (we) last saw the deceased alive on <b>December 8, 1967</b> , and that death occurred at <b>10 P.M.</b> from the causes and on the date stated above.   |                              |  |                                      |
| 22a. SIGNATURE<br><b>Richard N. Tillman</b>   |                              | 22b. DATE SIGNED<br><b>December 17, 1967</b>   |                                      |
| 22c. PHYSICIAN'S NAME (Type)<br><b>Richard N. Tillman</b>   |                              | 22d. ADDRESS<br><b>Green Mount Crematory Baltimore, Md.</b>  |                                      |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Cremation</b>   |                              | 23b. DATE THEREOF<br><b>12/18/67</b>   |                                      |
| 23c. NAME OF CEMETERY OR CREMATORY<br><b>Green Mount Crematory</b>  |                              | 23d. LOCATION (City, town or county) (State)<br><b>Baltimore, Md.</b>  |                                      |
| 24. FUNERAL DIRECTOR'S SIGNATURE<br><b>Wm. J. Tickner &amp; Sons Balto., Md.</b>  |                              | 25a. RECEIVED BY REGISTRAR<br><b>DEC 21 1967</b>   |                                      |
| 25b. REGISTRAR'S SIGNATURE<br><b>James Judge</b>  |                              |  |                                      |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

| MARYLAND STATE DEPARTMENT OF HEALTH  |  |  |   |   |   |   |  |   |   |
|--|--|--|---|---|---|---|--|---|---|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |  |   |   |   |   |  |   |   |
| CERTIFICATE OF DEATH   |  |  |   |   |   |   |  |   |   |
| 1 PLACE OF DEATH<br>a. COUNTY <b>BALTIMORE</b> MARYLAND  |  |  |   |   | 2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <b>MARYLAND</b> b. COUNTY <b>BALT.</b> |   |  |   |   |
| b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>CATONSVILLE</b>  |  |  | c. LENGTH OF STAY in 1b<br><b>4 mo. 8 days</b>  |   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>BALTIMORE</b>                                    |   |  |   |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>SPRING GROVE STATE HOSP</b>   |  |  |   |   | d. STREET ADDRESS<br><b>5903 CECIL AVE</b>  |   |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |
| 3 NAME OF DECEASED<br>(Type or print)<br>First <b>ALONZO</b> Middle <b>M.</b> Last <b>MATHIAS</b>  |  |  |   |   | 4. DATE OF DEATH<br>Month <b>DEC</b> Day <b>10</b> Year <b>1967</b>   |   |  |   |   |
| 5. SEX<br><b>MALE</b>  |  | 6. COLOR OR RACE<br><b>WHITE</b>       |   | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 8. DATE OF BIRTH<br><b>1-22-1893</b>                                  |  | 9. AGE (In years last birthday)<br><b>74</b> yrs.   |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Mechanic</b>   |  |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>GAS ELEC. Co.</b>   |   |   | 11 BIRTHPLACE (County & State, or foreign country)<br><b>MARYLAND</b> |  | 12 CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |   |
| 13. FATHER'S NAME<br><b>William Mathias</b>  |  |  |   |   | 14. MOTHER'S MAIDEN NAME<br><b>Amelia Horton</b>  |   |  |   |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) (If yes give war or dates of service)   |  |  | 16. SOCIAL SECURITY NO.<br><b>220-01-2489</b>   |   | 17. INFORMANT<br><b>Mrs. Barbara Mathias</b>  |   | Address <b>5903 Cecil Ave 21207</b>  |   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))<br>PART I. DEATH WAS CAUSED BY.<br>IMMEDIATE CAUSE (a) <b>myocardial infarction</b><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>Arteriosclerotic cardiovascular disease</b><br>DUE TO<br>(c) <b>Generalized Arteriosclerosis</b> |  |  |   |   |   |   |  |   | INTERVAL BETWEEN ONSET AND DEATH  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |  |  |   |   |   |   |  |   | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)   |   |   |   |  |   |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. _____ p.m. <b>19</b>   |  |  | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> at work <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> |   | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |   | 20f. (City or town) (County) (State)                                       |   |   |
| 21. I certify that (H) (this hospital) attended the deceased from <b>AUG 2, 1967</b> , to <b>DEC 10, 1967</b> , that (H) (we) last saw the deceased alive on <b>Dec. 10, 1967</b> , and that death occurred at <b>3:19 AM</b> , from causes and on the date stated above.  |  |  |   |   |   |   |  |   |   |
| 22a. SIGNATURE<br><b>Olive Reid Harris MD</b>  |  |  |   |   | M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>    |   | 22b. DATE SIGNED<br><b>12-10-67</b>  |   |   |
| 22c. PHYSICIAN'S NAME (Type) <b>Olive Reid Harris</b>  |  |  |   |   | 22d. ADDRESS<br><b>SPRING GROVE</b>   |   |  |   |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>   |  | 23b. DATE THEREOF<br><b>12-13-1967</b> |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Lorraine Park Cemetery</b>   |   |   | 23d. LOCATION (City or Town) (County) (State)<br><b>Woodlawn, Maryland</b> |   |   |
| 24. FUNERAL DIRECTOR<br><b>Howard H. Hubbard, 4107 Wilkens Ave.</b>  |  |  |   |   | 25a. REC'D BY REGISTRAR<br><b>DEC 12 1967</b>   |   | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Jones</b>                         |   |   |





FOR STATE  
HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate shall be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME  
350D 4-64

| <div> <div>1</div> <div> <div>16606</div> <div>21222</div> <div>50 YRS.</div> </div> <div> <div>16592</div> <div>21222</div> <div>50 YRS.</div> </div> </div> <div> <div> <div>16606</div> <div>21222</div> <div>50 YRS.</div> </div> <div> <div>16592</div> <div>21222</div> <div>50 YRS.</div> </div> </div>   |  |  |  |  |  |  |  |  |  |
|--|--|--|--|--|--|--|--|--|--|
| <b>1. PLACE OF DEATH</b><br>a. COUNTY <b>BALTIMORE</b> <b>21222</b> <b>MARYLAND</b><br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>DUNDALK</b><br>c. LENGTH OF STAY in 1b <b>50 YRS.</b><br>d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>55 NORTHSHIP ROAD</b>  |  |  |  |  | <b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission)<br>a. STATE <b>MARYLAND</b> <b>b. COUNTY BALTIMORE</b><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>DUNDALK</b><br>d. STREET ADDRESS <b>55 NORTHSHIP ROAD</b><br>e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |  |
| <b>3. NAME OF DECEASED</b> (Type or print) <b>RALPH FRANKLIN MATTOX</b><br><b>5. SEX</b> <b>MALE</b> <b>6. COLOR OR RACE</b> <b>CAUCASIAN</b> <b>7. MARRIED</b> <input checked="" type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/><br><b>8. DATE OF BIRTH</b> <b>21 SEPT. 1898</b> <b>9. AGE</b> (In years last birthday) <b>69</b> <b>yrs.</b> <b>Months</b> <b>Days</b> <b>Hours</b> <b>Min.</b><br><b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>GENL. YARD MASTER</b> <b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>RAILROAD</b><br><b>11. BIRTHPLACE</b> (State or foreign country) <b>PENNSYLVANIA</b> <b>12. CITIZEN OF WHAT COUNTRY?</b> <b>USA</b><br><b>13. FATHER'S NAME</b> <b>CHARLES W. MATTOX</b> <b>14. MOTHER'S MAIDEN NAME</b> <b>IDA BELLE KERR</b><br><b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <b>NO</b> <b>16. SOCIAL SECURITY NO.</b> <b>705/10/9446</b> <b>17. INFORMANT</b> <b>INA B. MATTOX-WIDOW-</b> <b>Address</b> <b>AS IN # 2 ABOVE</b>   |  |  |  |  |  |  |  |  |  |
| <b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).]<br><b>PART I. DEATH WAS CAUSED BY:</b><br><b>IMMEDIATE CAUSE (a)</b> <b>Crown Aneurysm</b><br><b>(b)</b> <b>A-S-C-V-Disease</b><br><b>(c)</b><br><b>CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last.</b><br><b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b><br><b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |  |  |  |  |  |  |  |  |
| <b>20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.</b> <b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) <b>None</b><br><b>20c. TIME OF INJURY</b> Month, Day, Year <b>19</b> <b>20d. INJURY OCCURRED</b> <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <b>20f. (City or town)</b> <b>(County)</b> <b>(State)</b><br><b>21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and in my opinion death resulted from:</b> <b>Natural causes <input checked="" type="checkbox"/></b> <b>Accident <input type="checkbox"/></b> <b>Suicide <input type="checkbox"/></b> <b>Homicide <input type="checkbox"/></b> <b>Undetermined manner <input type="checkbox"/></b><br><b>ACTUAL SIGNATURE</b> <b>M. B. Davis</b> <b>M.D.</b> <b>CHIEF MEDICAL EXAMINER <input type="checkbox"/></b><br><b>ASSISTANT MEDICAL EXAMINER <input type="checkbox"/></b> <b>DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/></b> <b>22. DATE SIGNED</b> <b>12/28/67</b><br><b>EXAMINER'S NAME (Type)</b> <b>MELVIN B. DAVIS, MD. DUNDALK</b> <b>Address (Street, city, town, or county)</b> <b>1800 MONTGOMERY AVE. N.W. WASHINGTON, D.C.</b> |  |  |  |  |  |  |  |  |  |
| <b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>BURIAL</b> <b>23b. DATE THEREOF</b> <b>29/12/1967</b> <b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>MEADOWRIDGE</b> <b>23d. LOCATION (City, town or county)</b> <b>DORSEY, MARYLAND</b><br><b>24. FUNERAL DIRECTOR</b> <b>WALTER BROOKS BRADLEY, DUNDALK, MD.</b> <b>25a. REC'D BY REGISTRAR</b> <b>25b. REGISTRAR'S SIGNATURE</b> <b>DATE</b> <b>DEC 29 1967</b>   |  |  |  |  |  |  |  |  |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2, and 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16607

CERTIFICATE OF DEATH

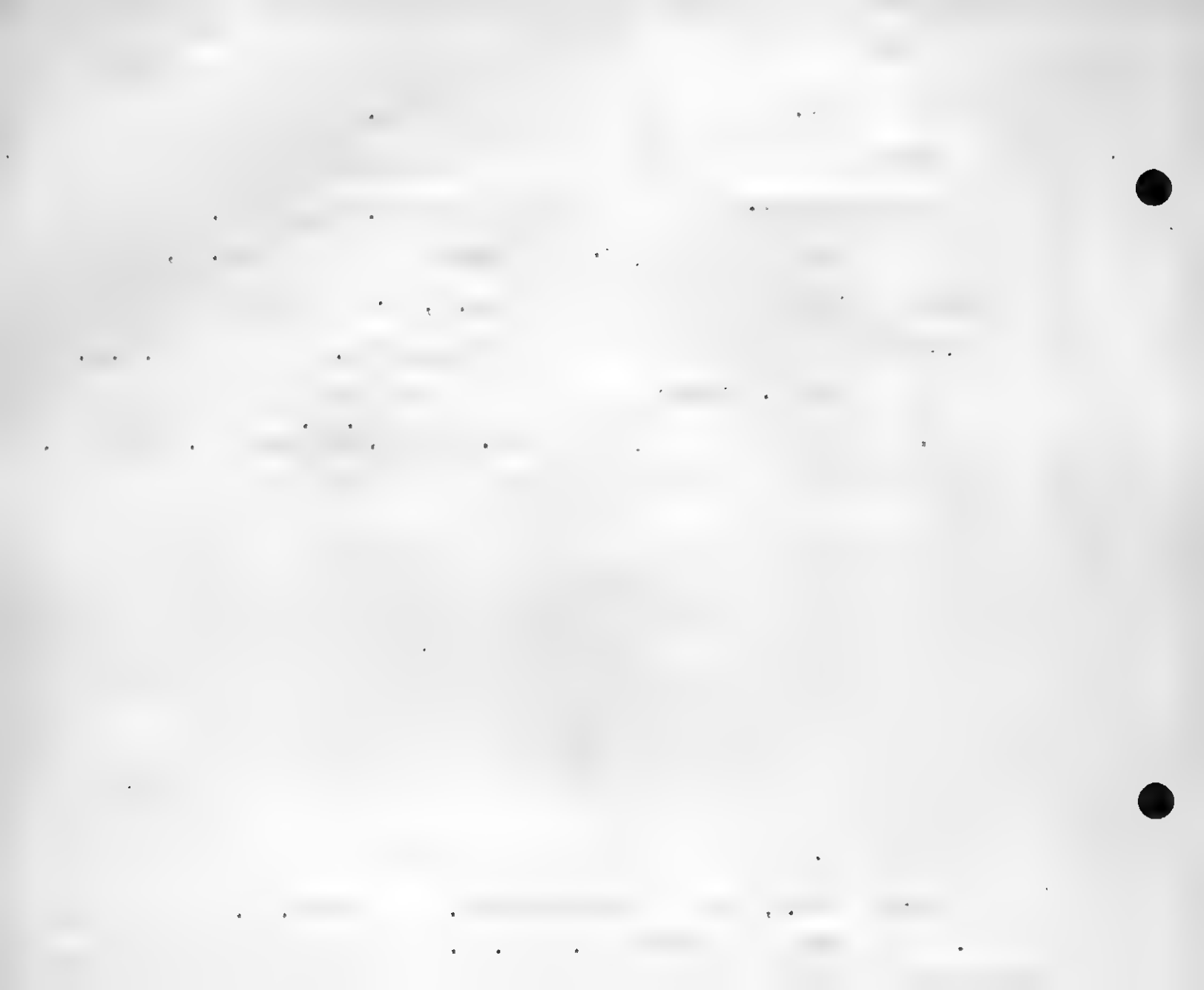
16600

|   |   |   |   |
|---|---|---|---|
| 1 PLACE OF DEATH<br>a. COUNTY <b>Baltimore</b> MARYLAND   |   | 2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY                                   |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Towson</b>   |   | c. LENGTH OF STAY IN lb<br><b>Baltimore</b>   |   |
| d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>St. Joseph Hospital</b>   |   | d. STREET ADDRESS<br><b>1508 Northgate Rd., 21218</b>   |   |
| 3 NAME OF DECEASED (Type or print)<br>First <b>LAURA</b> Middle <b>L.</b> Last <b>McCorquindale</b>   |   | 4. DATE OF DEATH<br>Month <b>December</b> Day <b>18</b> Year <b>1967</b>  |   |
| 5. SEX<br><b>Female</b>   | 6. COLOR OR RACE<br><b>White</b>  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>2/22/01</b>  |
| 9. AGE (In years last birthday)<br><b>66</b> yrs  |   | 10. IF UNDER 1 YEAR<br>Months Days Hours Mm   |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>HOUSEWIFE</b>   |   | 10b. KIND OF BUSINESS OR INDUSTRY   |   |
| 11. BIRTHPLACE (County & State, or foreign country)<br><b>Texas</b>   |   | 12. CITIZEN OF WHAT COUNTRY?  |   |
| 13. FATHER'S NAME<br><b>? DOBBYN</b>  |   | 14. MOTHER'S MAIDEN NAME<br><b>unknown</b>  |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)   |   | 16. SOCIAL SECURITY NO.   |   |
| 17. INFORMANT<br><b>hospital records</b>  |   | Address   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Hepatic coma</b><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>portal cirrhosis</b><br>DUE TO<br>(c) |   |   | INTERVAL BETWEEN ONSET AND DEATH  |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)   |   |   | 19. WAS AUTOPSY PERFORMED?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |   | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)   |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m. <b>19</b>  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  | 20f. (City or town) (County) (State)  |
| 21. I certify that <del>(X)</del> (this hospital) attended the deceased from <b>Dec. 11,</b> 1967, to <b>Dec. 18,</b> 1967, that <del>(X)</del> (we) last saw the deceased alive on <b>Dec. 18,</b> 1967, and that death occurred at <b>5:45 P.</b> from causes and on the date stated above.                   |   |   |   |
| 22a. SIGNATURE<br><b>William</b>  |   | 22b. DATE SIGNED<br><b>12/19/67</b>   |   |
| 22c. PHYSICIAN'S NAME (Type)<br><b>Ines Cilliani, M.D.</b>  |   | 22d. ADDRESS<br><b>7620 York Rd., Towson, Md., 21204</b>  |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>  | 23b. DATE THEREOF<br><b>12/21/67</b>  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>McAELAND</b>   | 23d. LOCATION (City or Town) (County) (State)<br><b>BALTO. MD.</b>                                |
| 24. FUNERAL DIRECTOR<br><b>E. S. MACNABB</b>  |   | 25a. REC'D BY REGISTRAR<br><b>DEC 27 1967</b>   |   |
| 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>  |   |   |   |



16603

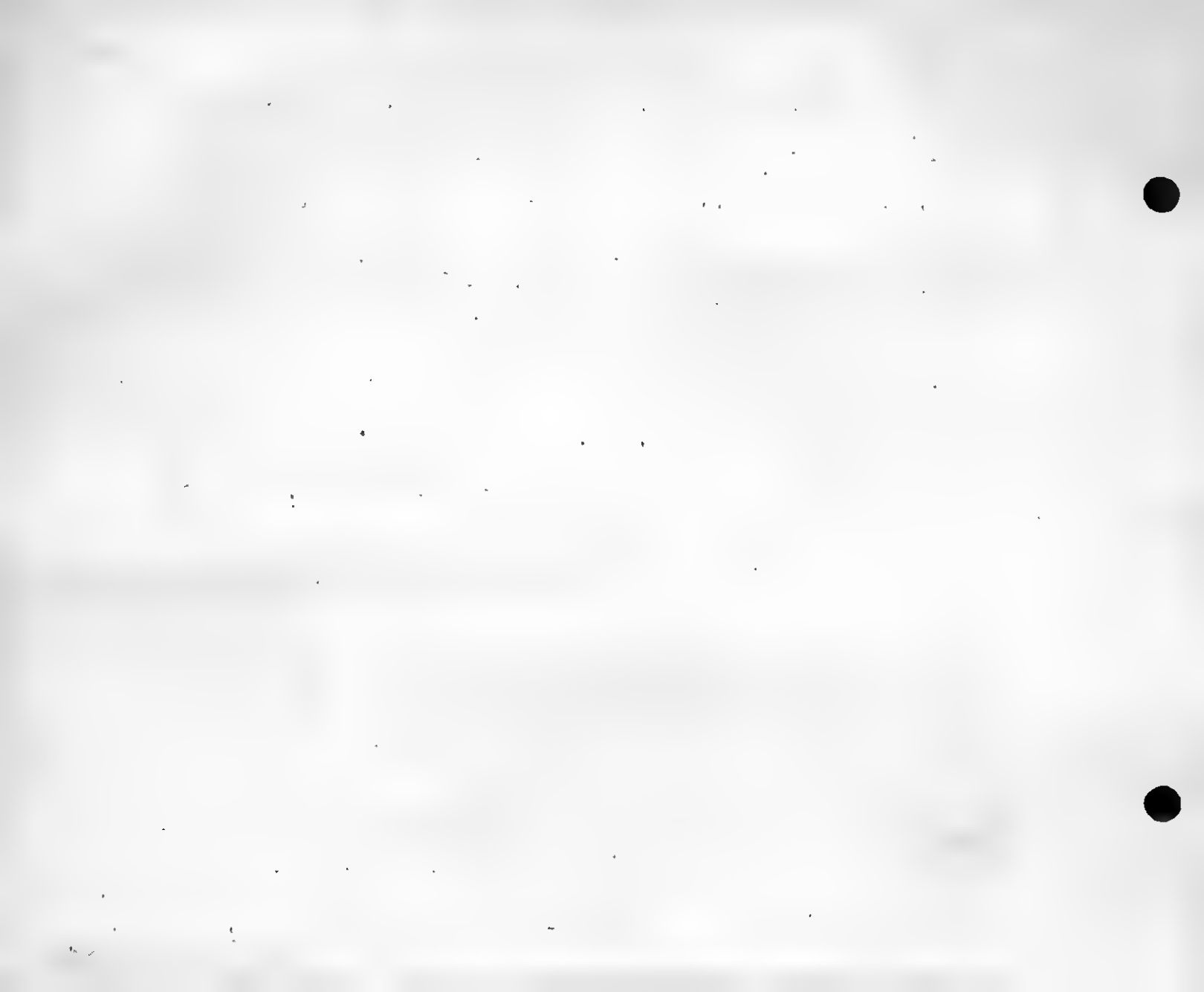
|  |  |   |  |
|--|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY<br><b>Balto.</b>  |  | 2. USUAL RESIDENCE (Where deceased lived; If institution: Residence before admission)<br>a. STATE<br><b>Md.</b>                                 |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Catonsville</b>   |  | c. LENGTH OF STAY IN 1b<br><b>Baltimore</b>   |  |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)<br><b>House In The Pines</b>  |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |
| 3. NAME OF DECEASED (Type or print)<br><b>Alice</b>  |  | 4. DATE OF DEATH<br><b>Dec. 7, 1967</b>   |  |
| 5. SEX<br><b>Female</b>  |  | 6. COLOR OR RACE<br><b>White</b>  |  |
| 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>   |  | 8. DATE OF BIRTH<br><b>Aug. 31, 1887</b>  |  |
| 9. AGE (In years last birthday)<br><b>80</b> yrs.  |  | 10. IF UNDER 1 YEAR: Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/> |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>House Keeper</b>   |  | 10b. KIND OF BUSINESS OR INDUSTRY   |  |
| 11. BIRTHPLACE (County & State, or foreign country)<br><b>Annapolis Md.</b>  |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U. S. A.</b>   |  |
| 13. FATHER'S NAME<br><b>John J. McCusker</b>   |  | 14. MOTHER'S MAIDEN NAME<br><b>Alice Walton</b>   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)<br><b>No.</b>  |  | 16. SOCIAL SECURITY NO.   |  |
| 17. INFORMANT<br><b>Balto. Md.</b>   |  | Address<br><b>21229 Miss. Corine A. McCusker 133 S. Augusta Ave.</b>  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>ATHEROSCLEROTIC CV Heart Disease</b><br>4221 DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)<br>DUE TO (c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br><b>① EMBOLIC ARTERIAL GANGRENE ② Bg ③ C.U.A.</b><br>20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)<br>20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)<br>20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. 19<br>p.m.<br>20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/><br>20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)<br>20f. (City or town) (County) (State)<br>21. I certify that (I) (this hospital) attended the deceased from <b>9-12, 1956</b> to <b>12-7, 1967</b> , that (I) (we) last saw the deceased alive on <b>12-7, 1967</b> , and that death occurred at <b>3 AM</b> , from the causes and on the date stated above.<br>22a. SIGNATURE<br><b>John F. Schaefer</b><br>22b. DATE SIGNED<br><b>12/8/67</b><br>22c. PHYSICIAN'S NAME (Type)<br><b>JOHN F. SCHAEFER MD</b><br>22d. ADDRESS<br><b>401 RANDOM RD. - 21229</b><br>23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b><br>23b. DATE THEREOF<br><b>Dec. 9, 1967</b><br>23c. NAME OF CEMETERY OR CREMATORY<br><b>New Cathedral Cem.</b><br>23d. LOCATION (City, town or county) (State)<br><b>Balto. Md.</b><br>24. FUNERAL DIRECTOR<br><b>G. Truman Schwab 3512 Frederick Ave. Balto. Md.</b><br>25a. REC'D BY REGISTRAR<br><b>DEC 11 1967</b><br>25b. REGISTRAR'S SIGNATURE<br><b>Charles J. [Signature]</b> |  |   |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper (pages 1 and 2) should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |  |  |   |   |  |   |  |  |  |
|---|--|--|---|---|--|---|--|--|--|
| CERTIFICATE OF DEATH  |  |  |   |   |  |   |  |  |  |
| 1 DECEASED NAME<br>(Type or print) <del>XXXXXX</del> Edley H. McDonald, Sr.   |  |  | 2a. DATE OF DEATH<br>Month Day Year<br>December 28 1967 |   |  | 2b. HOUR<br>M   |  |  |  |
| 3. SEX<br>Male  |  | 4 RACE<br>White  |   | 5. DATE OF BIRTH<br>9-29-1890   |  | 6. AGE (In years last birthday)<br>77 YRS.  |  | IF UNDER YEAR MONTHS DAYS HOURS MIN                |  |
| 7a. BIRTHPLACE (State or foreign country)<br>Hume, W. Virginia  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br>Baltimore Md.   |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>Woodlawn   |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br>6902 Windsor Mill Road |   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)<br>Engineer  |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE<br>Maryland   |  | 13b. COUNTY<br>Baltimore   |   | 13c. CITY OR TOWN<br>Baltimore  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET AND NUMBER<br>6902 Windsor Mill Road   |  |
| 14. FATHER'S NAME First Middle Last   |  |  | 15. MOTHER'S MAIDEN NAME First Middle Last              |   |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or unknown (If yes give war or dates of service)<br>NO   |  | 16b. SOCIAL SECURITY NO  |   | 17. INFORMANT Address<br>Annie McDonald-6902 Windsor Mill Road  |  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Intractable Congestive Heart Failure</u><br>4221<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(b) <u>Severe Aortic Insufficiency</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>ASCVD</u> |  |  |   |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH       |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><u>Senility - Cerebral Artery Insufficiency</u>  |  |  |   |   |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                            |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19   |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |   |  |  |  |
| 21d. INJURY OCCURRED<br>White <input type="checkbox"/> Not while at work <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)                           |   | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>1-6-</u> , 19 <u>66</u> , to <u>12-28</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>12-28-1967</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |  |   |   |  |   |  |  |  |
| 22b. SIGNATURE<br><u>Cesar Valle Cervero</u>  |  |  |   | DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>                        |  | 22c. DATE SIGNED<br>12-29-67  |  |  |  |
| 22d. PHYSICIAN'S NAME (Type)<br>CESAR VALLE CAVERO  |  |  |   | 22a. ADDRESS<br>8629 Liberty Rd   |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br>Burial   |  | 23b. DATE<br>1-2-68  |   | 23c. NAME OF CEMETERY OR CREMATORY<br>Woodlawn Cemetery   |  | 23d. LOCATION (City or Town) (County) (State)<br>Baltimore, Maryland                            |  |  |  |
| 24. FUNERAL DIRECTOR<br>Ellsworth Armacost-4600 Liberty Hghts. Ave  |  |  |   | ADDRESS   |  | 25a. REC'D BY REGISTRAR<br>JAN 3 1968   |  | 25b. REGISTRAR'S SIGNATURE<br><u>Charles Judge</u> |  |





TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If only delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health at its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

| <div style="text-align: center;"> <div>16649</div> <div> <div>Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201</div> <div>Item 25b Film G397 1/25/68 bk</div> </div> <div> <div>17890</div> <div> <div>1</div> <div>HEALTH DEPT.</div> </div> </div> </div>   |      |   |  |   |  |  |  |   |  |                 |  |                 |  |        |      |       |     |
|---|------|---|--|---|--|--|--|---|--|-----------------|--|-----------------|--|--------|------|-------|-----|
| <b>1. PLACE OF DEATH</b><br>a. COUNTY <b>BALTIMORE</b> MARYLAND   |      |   |  |   | <b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution. Residence before admission)<br>a. STATE <b>MARYLAND</b> b. COUNTY |  |  |   |  |                 |  |                 |  |        |      |       |     |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>FORT HOWARD</b>  |      |   | c. LENGTH OF STAY IN 1b<br><b>7 DAYS</b>   |   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>BALTIMORE 21225</b>                         |  |  |   |  |                 |  |                 |  |        |      |       |     |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>VETERANS ADMINISTRATION HOSPITAL</b>   |      |   |  |   | d. STREET ADDRESS<br><b>401 GIBBONS AVENUE</b>   |  |  | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |                 |  |                 |  |        |      |       |     |
| <b>3. NAME OF DECEASED</b> (Type or print)<br>First <b>JOHN</b> Middle <b>C.</b> Last <b>MELVIN</b>   |      |   |  |   | <b>4. DATE OF DEATH</b><br>Month <b>DECEMBER</b> Day <b>22</b> Year <b>19 67</b>   |  |  |   |  |                 |  |                 |  |        |      |       |     |
| <b>5. SEX</b><br><b>MALE</b>  |      | <b>6. COLOR OR RACE</b><br><b>NEGRO</b> |  | <b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | <b>8. DATE OF BIRTH</b><br><b>11/25/88</b>                         |  | <b>9. AGE</b> (n years last birthday) <b>79</b> yrs <table border="1"> <tr> <th colspan="2">IF UNDER 1 YEAR</th> <th colspan="2">IF UNDER 24 HRS</th> </tr> <tr> <td>Months</td> <td>Days</td> <td>Hours</td> <td>Min</td> </tr> </table> |  | IF UNDER 1 YEAR |  | IF UNDER 24 HRS |  | Months | Days | Hours | Min |
| IF UNDER 1 YEAR   |      | IF UNDER 24 HRS                         |  |   |  |  |  |   |  |                 |  |                 |  |        |      |       |     |
| Months  | Days | Hours                                   | Min  |   |  |  |  |   |  |                 |  |                 |  |        |      |       |     |
| <b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)<br><b>TRACK WALKER</b>   |      |   | <b>10b. KIND OF BUSINESS OR INDUSTRY</b><br><b>RAIL ROAD</b>   |   | <b>11. BIRTHPLACE</b> (State or foreign country)<br><b>ENGLAND</b>   |  |  | <b>12. CITIZEN OF WHAT COUNTRY?</b><br><b>U.S.A.</b>  |  |                 |  |                 |  |        |      |       |     |
| <b>13. FATHER'S NAME</b><br><b>HENRY MELVIN</b>   |      |   |  |   | <b>14. MOTHER'S MAIDEN NAME</b><br><b>RACHEL MC COY</b>  |  |  |   |  |                 |  |                 |  |        |      |       |     |
| <b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown)<br><b>YES WW I</b>   |      |   | <b>16. SOCIAL SECURITY NO.</b><br><b>220 12 03 69</b>  |   | <b>17. INFORMANT</b><br><b>CLIN. RECORDS, VA HOSPITAL, FT HOWARD, MD.</b>  |  |  |   |  |                 |  |                 |  |        |      |       |     |
| <b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>BRONCHOPNEUMONIA</b><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause<br>(b) <b>SMOKE INHALATION</b><br>DUE TO<br>(c) <b>SECOND DEGREE BURNS OF CHEST</b>  |      |   |  |   |  |  |  | <b>INTERVAL BETWEEN ONSET AND DEATH</b><br><b>3 DAYS</b><br><b>1 WEEK</b><br><b>9 DAYS</b>  |  |                 |  |                 |  |        |      |       |     |
| <b>PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b>   |      |   |  |   |  |  |  | <b>19. WAS AUTOPSY PERFORMED?</b><br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |                 |  |                 |  |        |      |       |     |
| <b>20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING?</b><br><b>CAUSE OF DEATH</b>  |      |   | <b>20b. DESCRIBE HOW INJURY OCCURRED</b> (Enter nature of injury in Part I or Part II of item 18)<br><b>Put burning material in pocket &amp; coughed on fire</b> |   |  |  |  |   |  |                 |  |                 |  |        |      |       |     |
| <b>20c. TIME OF INJURY</b> Month, Day, Year<br>Hour a.m. <b>12-13</b> 19 <b>67</b> p.m.   |      |   | <b>20d. INJURY OCCURRED</b><br>Where <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/> at work                                      |   | <b>20e. PLACE OF INJURY</b> (Home farm factory street office bldg etc)<br><b>Home</b>  |  | <b>20f. CITY OR TOWN</b> (County) (State)<br><b>Balto Md</b>                       |   |  |                 |  |                 |  |        |      |       |     |
| <b>21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and in my opinion death resulted from:</b><br>Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> |      |   |  |   |  |  |  |   |  |                 |  |                 |  |        |      |       |     |
| <b>ACTUAL SIGNATURE</b><br><b>MELVIN B. DAVIS</b>   |      |   | <b>CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/>   |   |  | <b>22. DATE SIGNED</b><br><b>12/22/67</b>                          |  |   |  |                 |  |                 |  |        |      |       |     |
| <b>EXAMINER'S NAME</b> (Type)<br><b>MELVIN B. DAVIS, M. D.</b>  |      |   | <b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/>   |   |  | <b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/> |  |   |  |                 |  |                 |  |        |      |       |     |
| <b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify)<br><b>BURIAL</b>   |      |   | <b>23b. DATE THEREOF</b><br><b>12-26-1967</b>  |   | <b>23c. NAME OF CEMETERY OR CREMATORY</b><br><b>BALTIMORE NATIONAL</b>   |  | <b>23d. LOCATION</b> (City or Town) (County) (State)<br><b>BALTIMORE, MARYLAND</b> |   |  |                 |  |                 |  |        |      |       |     |
| <b>24. FUNERAL DIRECTOR</b><br><b>ISIAH BROWN FUNERAL HOME</b>  |      |   | <b>ADDRESS</b><br><b>W. MONTGOMERY ST. BALTIMORE, MD.</b>  |   |  | <b>25a. RECEIVED BY REGISTRAR</b><br><b>JAN 12 1968</b>            |  | <b>25b. REGISTRAR'S SIGNATURE</b><br><b>J. L. Judge</b>   |  |                 |  |                 |  |        |      |       |     |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

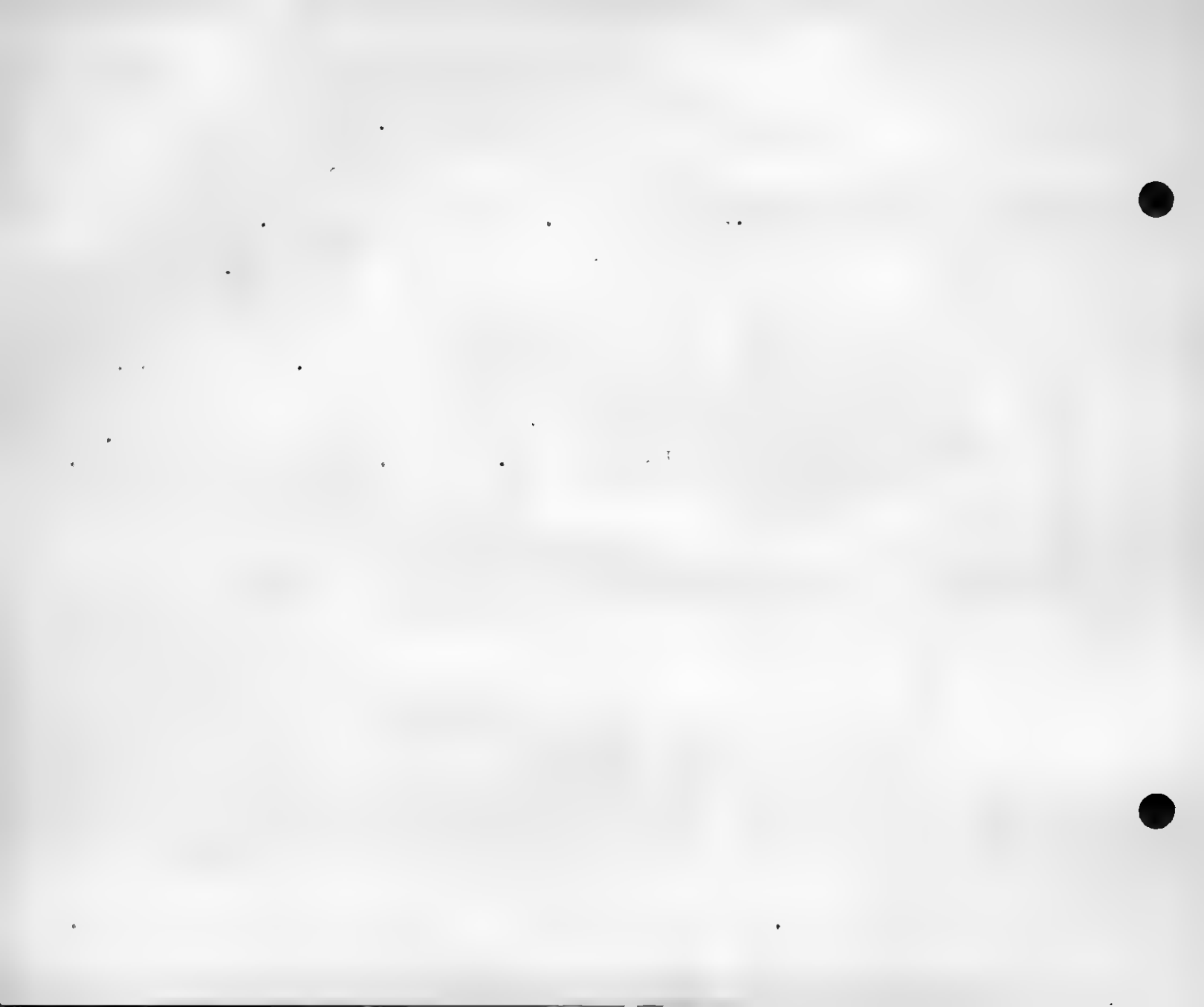
CERTIFICATE OF DEATH

16641

15604

|   |   |   |  |
|---|---|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Baltimore</u> MARYLAND  |   | 2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)<br>a. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u>                      |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)  |   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)  |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><u>1135 Granville Rd., Baltimore 7, Md.</u>   |   | d. STREET ADDRESS<br><u>1135 Granville Rd.</u>  |  |
| 3. NAME OF DECEASED<br>(Type or print) <u>Edward Edwin Miller</u>   |   | 4. DATE OF DEATH<br>Month <u>Dec.</u> Day <u>13</u> Year <u>1967</u>  |  |
| 5. SEX<br><u>Male</u>   | 6. COLOR OR RACE<br><u>White</u>  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><u>July 12, 1903</u>   |
| 9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Retired</u>  |   | 9b. KIND OF BUSINESS OR INDUSTRY<br><u>Hollinger Gulf Oil</u>   | 9c. AGE (in years last birthday)<br><u>64</u> yrs                                  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Retired</u>   |   | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>Hollinger Gulf Oil</u>  | 10c. CITIZEN OF WHAT COUNTRY?<br><u>U.S.A.</u>                                     |
| 11. BIRTHPLACE (County & State, or foreign country)<br><u>Baltimore, Md.</u>  |   | 12. CITIZEN OF WHAT COUNTRY?<br><u>U.S.A.</u>   |  |
| 13. FATHER'S NAME<br><u>Michael Chmielewski</u>   |   | 14. MOTHER'S MAIDEN NAME<br><u>Johanna Kroeger</u>  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><u>No</u>  |   | 16. SOCIAL SECURITY NO<br><u>213-14-2872</u>  |  |
| 17. INFORMANT<br><u>Mr. Edward H. Miller, 3101 Northwind Rd.</u>  |   | 18. ADDRESS<br><u>Baltimore, Md. 21234</u>  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Carcinoma Stomach &amp; general</u><br>DUE TO (b) <u>Metastases.</u><br>DUE TO (c) <u>Thrombosis.</u>                           |   | INTERVAL BETWEEN ONSET AND DEATH<br><u>Opuntia</u><br><u>9 yrs ago.</u>   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |   |   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. _____ p.m. <u>19</u>  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  | 20f. (City or town) (County) (State)   |
| 21. I certify that (I) (this hospital) attended the deceased from <u>Feb 9, 1952</u> to <u>Dec 13, 1967</u> , that (I) (we) last saw the deceased alive on <u>Dec 12, 1967</u> , and that death occurred at <u>7 PM</u> , from causes and on the date stated above. |   |   |  |
| 22a. SIGNATURE<br><u>Nathan E. Needle</u> M.D.  |   | 22b. DATE SIGNED<br><u>12/15/67</u>   |  |
| 22c. PHYSICIAN'S NAME (Type)<br><u>NATHAN E. NEEDLE</u>   |   | 22d. ADDRESS<br><u>6506 Park Hyatt Dr</u>   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial</u>  | 23b. DATE THEREOF<br><u>Dec. 16, 1967</u>   | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Lakeview Memorial Cemetery</u>   | 23d. LOCATION (City or Town) (County) (State)<br><u>Randallstown, Baltio., Md.</u> |
| 24. FUNERAL DIRECTOR<br><u>Frank H. Howell, Pikesville, Md.</u>   |   | 25a. REC'D BY REGISTRAR<br>DATE <u>DEC 18 1967</u>  | 25b. REGISTRAR'S SIGNATURE<br><u>Charles Judge</u>                                 |

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

| MARYLAND STATE DEPARTMENT OF HEALTH  |  |                               |  |  |  |   |  |   |   |   |  |
|--|--|-------------------------------|--|--|--|---|--|---|---|---|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |                               |  |  |  |   |  |   |   |   |  |
| CERTIFICATE OF DEATH   |  |                               |  |  |  |   |  |   |   |   |  |
| 1. PLACE OF DEATH<br>a. COUNTY <b>Baltimore</b><br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Mount Wilson</b><br>c. LENGTH OF STAY IN It <b>12 days</b><br>d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Mount Wilson State Hospital</b> |  |                               |  |  |  | 2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b><br>c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>City</b><br>d. STREET ADDRESS <b>5111 Green Oak Ave</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |   |   |   |  |
| 3. NAME OF DECEASED (Type or print) <b>George William Miller</b><br>First Middle Last  |  |                               |  |  |  | 4. DATE OF DEATH <b>Dec. 30 1967</b><br>Month Day Year  |  |   |   |   |  |
| 5. SEX <b>Male</b>   |  | 6. COLOR OR RACE <b>White</b> |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH <b>3-25-1877</b>   |  | 9. AGE (In years last birthday) <b>90 yrs</b>                   |   | 10. IF UNDER 1 YEAR Months Days Hours Min |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Chief Manager - President Life Ins Co</b>   |  |                               |  |  |  | 10b. KIND OF BUSINESS OR INDUSTRY <b>W. Va.</b>   |  |   | 11. BIRTHPLACE (County & State, or foreign country) <b>W. Va.</b> |   |  |
| 13. FATHER'S NAME <b>John Miller</b>   |  |                               |  |  |  | 14. MOTHER'S MAIDEN NAME <b>Elizabeth Miller</b>  |  |   |   |   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes give war or dates of service)  |  |                               |  |  |  | 16. SOCIAL SECURITY NO <b>215-16-5443</b>   |  |   |   |   |  |
| 17. MEDICAL RECORD NO <b>210</b>   |  |                               |  |  |  | 18. MEDICAL RECORD NO <b>215-16-5443</b>  |  |   |   |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))   |  |                               |  |  |  |   |  |   |   |   |  |
| PART I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |  |                               |  |  |  |   |  |   |   |   |  |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |                               |  |  |  |   |  |   |   |   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |                               |  |  |  |   |  |   |   |   |  |
| 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)   |  |                               |  |  |  |   |  |   |   |   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m. <b>19</b>   |  |                               |  | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Not While <input type="checkbox"/><br>at work at work   |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |  | 20f. (City or town) (County) (State)                            |   |   |  |
| 21. I certify that (I) (this hospital) attended the deceased from <b>Dec. 18, 1967</b> to <b>Dec. 30, 1967</b> that (I) (we) last saw the deceased alive on <b>Dec. 30, 1967</b> , and that death occurred at <b>8:41 AM</b> , from causes and on the date stated above.   |  |                               |  |  |  |   |  |   |   |   |  |
| 22a. SIGNATURE <b>W. Newcomer</b>  |  |                               |  |  |  | 22b. DATE SIGNED  |  |   |   |   |  |
| 22c. PHYSICIAN'S NAME (Type) <b>Wm. Newcomer, M.D., Superintendent</b>   |  |                               |  |  |  | 22d. ADDRESS <b>Mount Wilson, Maryland</b>  |  |   |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>  |  |                               |  | 23b. DATE THEREOF <b>1-2-68</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY <b>Woodlawn Cemetery</b>   |  | 23d. LOCATION (City or town) (County) (State) <b>Balto, Md.</b> |   |   |  |
| 24. FUNERAL DIRECTOR <b>Elsworth Armacost</b>  |  |                               |  |  |  | 25a. REC'D BY REGISTRAR <b>JAN 2 1968</b>   |  | 25b. REGISTRAR'S SIGNATURE <b>Charles J. Jones</b>              |   |   |  |



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If duly deo is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE  
HEALTH DEPT.

1

16613

M

| MARYLAND STATE DEPARTMENT OF HEALTH   |  |                                 |  |   |  |  |  |  |  |  |  |
|---|--|---------------------------------|--|---|--|--|--|--|--|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |  |                                 |  |   |  |  |  |  |  |  |  |
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH   |  |                                 |  |   |  |  |  |  |  |  |  |
| 13606   |  |                                 |  |   |  |  |  |  |  |  |  |
| 1 PLACE OF DEATH<br>a COUNTY <u>Baltimore</u> MARYLAND  |  |                                 |  |   |  | 2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a STATE <u>Pennsylvania</u><br>b COUNTY <u>✓</u> |  |  |  |  |  |
| b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Essex-</u>  |  |                                 |  | c LENGTH OF STAY N 1b   |  | c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Upper Black Eddy</u>                               |  |  |  |  |  |
| d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><u>BALTO YACHT CLUB</u>  |  |                                 |  |   |  | d STREET ADDRESS<br><u>Chestnut Ridge Road</u>   |  |  |  | e RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 3 NAME OF DECEASED<br>(Type or print) <u>Gerald F. Miller</u>   |  |                                 |  |   |  | 4 DATE OF DEATH<br>Month <u>12</u> Day <u>9</u> Year <u>1967</u>   |  |  |  |  |  |
| 5 SEX<br><u>Male</u>  |  | 6 COLOR OR RACE<br><u>White</u> |  | 7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8 DATE OF BIRTH<br><u>Jan. 11, 1947</u>  |  | 9 AGE (in years last birthday) yrs <u>20</u>   |  | 10 UNDER 1 YEAR<br>Months <u>12</u> Days <u>9</u> Hours <u>19</u> Min <u>67</u>    |  |
| 10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Seaman</u>   |  |                                 |  | 10b KIND OF BUSINESS OR INDUSTRY<br><u>US Coastguard</u>  |  | 11 BIRTHPLACE (State or foreign country)<br><u>Maryland</u>  |  |  |  | 12 CITIZEN OF WHAT COUNTRY?<br><u>U.S.</u>   |  |
| 13 FATHER'S NAME<br><u>Lloyd James Miller</u>   |  |                                 |  |   |  | 14 MOTHER'S MAIDEN NAME<br><u>Setpanen Siakka</u>  |  |  |  |  |  |
| 15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><u>Yes</u>  |  |                                 |  | 16 SOCIAL SECURITY NO<br><u>210-38-9851</u>   |  | 17 INFORMANT<br><u>Records-U.S. Coastguard</u> Address   |  |  |  |  |  |
| 18 CAUSE OF DEATH (Enter on any one cause per line for (a), (b) and (c))<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>DROWNING</u><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:<br>(b) <u>7198</u><br>DUE TO<br>(c)  |  |                                 |  |   |  |  |  |  |  |  |  |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)<br>19 WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |                                 |  |   |  |  |  |  |  |  |  |
| 20a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |  |                                 |  | 20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of item 18)  |  |  |  |  |  |  |  |
| 20c TIME OF INJURY Month, Day, Year<br>Hour a.m. <u>11-14</u> 1967<br>p.m.  |  |                                 |  | 20d INJURY OCCURRED While <input checked="" type="checkbox"/> Not While <input type="checkbox"/> at work at work  |  | 20e PLACE OF INJURY (Home, farm, highway, street, place, etc.)<br><u>Ches. Bay</u>   |  | 20f (City or town) (County) (State)<br><u>Ches. Bay</u> <u>Ches. Bay</u> <u>Del.</u> |  |  |  |
| 21 I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from. Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |  |                                 |  |   |  |  |  |  |  |  |  |
| ACTUAL SIGNATURE<br><u>M.B. Davis</u>   |  |                                 |  | 22 DATE SIGNED<br><u>12/9/67</u>  |  |  |  |  |  |  |  |
| EXAMINER'S NAME (Type)<br><u>M.B. DAVIS MD</u>  |  |                                 |  | 23a REC'D BY REGISTRAR<br><u>DEC 11 1967</u>  |  |  |  |  |  |  |  |
| 23a BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial</u>   |  |                                 |  | 23b DATE THEREOF<br><u>Dec. 12, 1967</u>  |  | 23c NAME OF CEMETERY OR CREMATORY<br><u>Upper Tinicum</u>  |  | 23d LOCATION (City or town) (County) (State)<br><u>Upper Black Eddy, Penna.</u>      |  | 25b REGISTRAR'S SIGNATURE<br><u>Charles Judge</u>                                  |  |
| 24 FUNERAL DIRECTOR<br><u>Howard County Funeral Home of Harry H. Witzke</u>   |  |                                 |  | ADDRESS<br><u>Ellicott City, Md.</u>  |  | 25a REC'D BY REGISTRAR<br><u>DEC 11 1967</u>   |  | 25b REGISTRAR'S SIGNATURE<br><u>Charles Judge</u>                                    |  |  |  |





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

| MARYLAND STATE DEPARTMENT OF HEALTH  |  |  |  |   |  |   |  |  |  |   |  |
|--|--|--|--|---|--|---|--|--|--|---|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |  |  |   |  |   |  |  |  |   |  |
| Item 24 Filed 0396 1 1/68  |  |  |  |   |  |   |  |  |  |   |  |
| 16614  |  |  |  |   |  |   |  |  |  |   |  |
| 13607  |  |  |  |   |  |   |  |  |  |   |  |
| CERTIFICATE OF DEATH   |  |  |  |   |  |   |  |  |  |   |  |
| 1 PLACE OF DEATH<br>a COUNTY <b>BALTIMORE</b><br>b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>TOWSON</b><br>c LENGTH OF STAY IN 1b   |  |  |  |   |  | 2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a STATE <b>MARYLAND</b><br>b COUNTY <b>BALTIMORE</b><br>c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Towson</b> |  |  |  |   |  |
| d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>ST. JOSEPH HOSPITAL</b>   |  |  |  |   |  | d. STREET ADDRESS <b>3039 THIRD AVE. #21234</b>   |  |  |  |   |  |
| 3. NAME OF DECEASED<br>(Type or print) <b>ANNABELLE THERESA MILLILI</b>  |  |  |  |   |  | 4 DATE OF DEATH<br>Month <b>DECEMBER</b> Day <b>25</b> Year <b>19 67</b>  |  |  |  |   |  |
| 5. SEX <b>FEMALE</b>   |  | 6. COLOR OR RACE <b>WHITE</b>          |  | 7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8 DATE OF BIRTH <b>OCTOBER 3, 1928</b>  |  | 9 AGE (in years last birthday) <b>39 yrs</b>   |  | IF UNDER 1 YEAR<br>Months Days Hours Min.   |  |
| 10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>  |  |  |  | 10b KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>  |  | 11 BIRTHPLACE (County & State, or foreign country) <b>Pennsylvania</b>  |  |  |  | 12 CITIZEN OF WHAT COUNTRY <b>USA</b>   |  |
| 13. FATHER'S NAME <b>Charles Wahler</b>  |  |  |  |   |  | 14 MOTHER'S MAIDEN NAME <b>Helen Willard</b>  |  |  |  |   |  |
| 15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>   |  |  |  | 16 SOCIAL SECURITY NO. <b>None</b>  |  | 17. INFORMANT <b>Family records</b>   |  |  |  | Address   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))   |  |  |  |   |  |   |  |  |  |   |  |
| PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Massive intracerebral hemorrhage</b>  |  |  |  |   |  |   |  |  |  |   |  |
| DUE TO (b) <b>Rupture of Berry aneurysm of left middle cerebral artery</b>   |  |  |  |   |  |   |  |  |  |   |  |
| DUE TO (c)   |  |  |  |   |  |   |  |  |  |   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)   |  |  |  |   |  |   |  |  |  |   |  |
| 20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  |  |   |  | 20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)  |  |  |  |   |  |
| 20c TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m. <b>19</b>  |  |  |  | 20d INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>  |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |  | 20f (City or town) (County) (State)  |  | 19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 21. I certify that (I) (this hospital) attended the deceased from <b>DECEMBER 24, 1967</b> , to <b>December 25, 19 67</b> that (I) (we) last saw the deceased alive on <b>DECEMBER 25 19 67</b> , and that death occurred at <b>1:10AM</b> , from causes and on the date stated above. |  |  |  |   |  |   |  |  |  |   |  |
| 22a. SIGNATURE <b>Sam G. Misanik</b>   |  |  |  |   |  | M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>  |  | 22b. DATE SIGNED <b>12-25-67</b>   |  |   |  |
| 22c. PHYSICIAN'S NAME (Type) <b>Lawrence Misanik, M.D.</b>   |  |  |  |   |  | 22d. ADDRESS <b>7620 York Road, Towson, Md. 21204</b>   |  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>  |  | 23b. DATE THEREOF <b>Dec. 29, 1967</b> |  | 23c. NAME OF CEMETERY OR CREMATORY <b>Holy Sepulchre Cemetery</b>   |  |   |  | 23d. LOCATION (City or Town) (County) (State) <b>Cheltenham Twp., Montgomery Co.</b> |  |   |  |
| 24. FUNERAL DIRECTOR <b>John Burn's Sons</b>   |  |  |  |   |  | ADDRESS <b>Towson, Maryland</b>   |  | 25a REC'D BY REGISTRAR   |  | 25b REGISTRAR'S SIGNATURE <b>1a.</b>  |  |
|  |  |  |  |   |  | DATE <b>DEC 28 1967</b>   |  |  |  |   |  |

MEDICAL CERTIFICATION



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

16615

10608

|  |  |   |   |
|--|--|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Baltimore</u> MARYLAND   |  | 2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission)<br>a. STATE <u>Maryland</u> b. COUNTY <u>Balto.</u>                   |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Randall's Town Md.</u>  |  | c. LENGTH OF STAY IN 1b<br><u>2207</u>  |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><u>Baltimore County General Hospital</u>   |  | d. STREET ADDRESS<br><u>3605 Marmon Ave</u>   |   |
| 3. NAME OF DECEASED<br>(Type or print) <u>Ross F. Mitten</u>   |  | 4. DATE OF DEATH<br>Month <u>12</u> Day <u>13</u> Year <u>1967</u>  |   |
| 5. SEX <u>M</u>  | 6. COLOR OR RACE <u>W</u>  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>6/3/1891</u> AGE (In years last birthday) <u>76</u> yrs |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Plumber</u>  |  | 10b. KIND OF BUSINESS OR INDUSTRY   |   |
| 11. BIRTHPLACE (State or foreign country)<br><u>Westminster, Md.</u>   |  | 12. CITIZEN OF WHAT COUNTRY?<br><u>USA</u>  |   |
| 13. FATHER'S NAME<br><u>Frank J. Mitten</u>  |  | 14. MOTHER'S MAIDEN NAME<br><u>Buckingham</u>   |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><u>No</u>   |  | 16. SOC. A. SECURITY NO.<br><u>218-18-2791</u>  |   |
| 17. INFORMANT<br><u>Ivy Rebecca Mitten, 3605 Marmon Avenue</u>   |  | Address   |   |
| 18. CAUSE OF DEATH (Enter on only one cause per line for (a), (b), and (c))<br>PART I DEATH WAS CAUSED BY<br><u>43X</u> IMMEDIATE CAUSE (a) <u>Cardio-vascular disease</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost<br>DUE TO (b) _____<br>DUE TO (c) _____  |  | INTERVAL BETWEEN ONSET AND DEATH<br><u>sudden</u>   |   |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br><u>Hypertension</u>  |  | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>   |  | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)  |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. _____ p.m. <u>19</u>   | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  | 20f. (City or town) (County) (State)  |
| 21. I certify that I took charge of the remains described above held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> |  |   |   |
| ACTUAL SIGNATURE <u>J. N. Frederick MD</u>   |  | CHIEF MEDICAL EXAMINER <input type="checkbox"/>   |   |
| EXAMINER'S NAME (Type) <u>J. N. Frederick MD</u>   |  | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>   |   |
|  |  | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>   |   |
|  |  | Address (Street, city, town, or county) <u>1311 Francis Ave 21227</u>   |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial</u>   | 23b. DATE THEREOF<br><u>12-16-67</u>   | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Lorraine Park Cemetery Baltimore, Maryland</u>   | 23d. LOCATION (City or Town) (County) (State)                               |
| 24. FUNERAL DIRECTOR <u>4600 Liberty Heights Avenue Ellsworth Armacost Funeral Chapel</u>  |  | 25a. RECEIVED BY REGISTRAR <u>DEC 15 1967</u> 25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>   |   |

11

1-1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

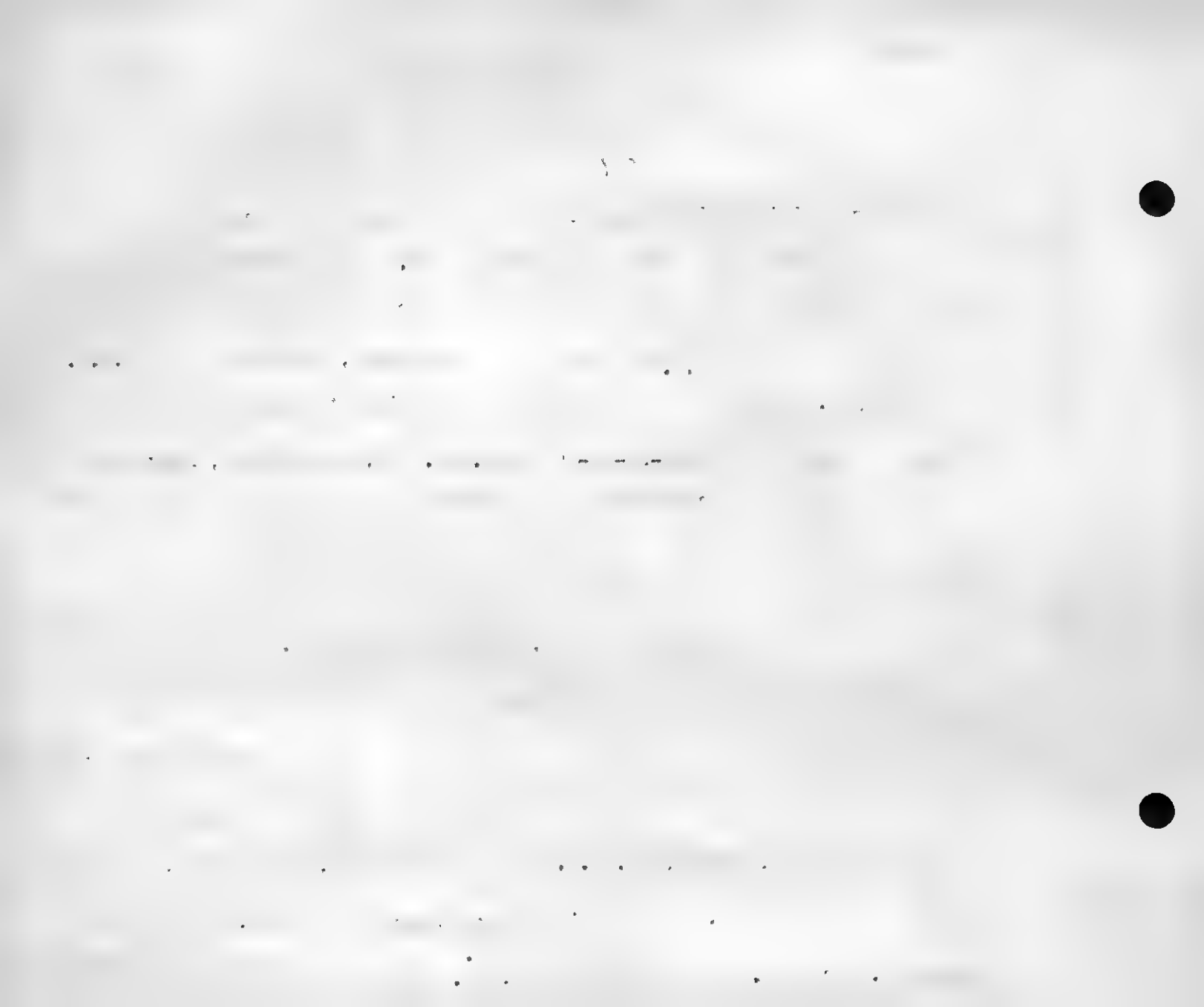
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16616 Item#3 Film#0319 3/27/68

CERTIFICATE OF DEATH

13609

|  |                                 |  |  |  |   |  |  |
|--|---------------------------------|--|--|--|---|--|--|
| 1 PLACE OF DEATH<br>a COUNTY <b>Baltimore</b> MARYLAND   |                                 |  |  | 2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission)<br>a STATE <b>Maryland</b> b COUNTY           |   |  |  |
| b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Fort Howard</b>  |                                 |  | c LENGTH OF STAY IN 1b<br><b>27 days</b> |  | c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Baltimore</b> |  |  |
| d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>Veterans Administration Hospital</b>   |                                 |  |  | d STREET ADDRESS<br><b>2811 Bayonne Avenue</b>   |   |  | e IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 3 NAME OF DECEASED (Type or print)<br><b>HARRY</b>   |                                 | First Middle Last<br><b>SCOTT MONKS</b>  |  | 4 DATE OF DEATH<br>Month <b>DECEMBER</b> Day <b>31</b> Year <b>1967</b>  |   |  |  |
| 5 SEX<br><b>Male</b>   | 6 COLOR OR RACE<br><b>White</b> | 7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8 DATE OF BIRTH<br><b>5/12/99</b>        |  | 9 AGE (In years last birthday) yrs<br><b>68</b>   | IF UNDER 1 YEAR<br>Months Days Hours Min   |  |
| 10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Clerk</b>   |                                 | 10b KIND OF BUSINESS OR INDUSTRY<br><b>U.S. Post Office</b>  |  | 11 BIRTHPLACE (County & State, or foreign country)<br><b>Baltimore, Maryland</b>   |   | 12 CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  |
| 13 FATHER'S NAME<br><b>Harry S. Monks</b>  |                                 |  |  | 14 MOTHER'S MAIDEN NAME<br><b>Elizabeth Lingan</b>   |   |  |  |
| 15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><b>Yes WWII</b>  |                                 | 16 SOCIAL SECURITY NO<br><b>108-44-57-70</b>   |  | 17 INFORMANT Address<br><b>Clin. Rec. VAH, Fort Howard, Maryland</b>   |   |  |  |
| 18 CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c))<br>PART I DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <b>CARCINOMA OF THE PANCREAS</b><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) DUE TO<br>(c) |                                 |  |  |  |   | INTERVAL BETWEEN ONSET AND DEATH<br><b>MONTHS</b>  |  |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br><b>CHRONIC PASSIVE CONGESTION OF LIVER. PULMONARY EMPHYSEMA.</b>   |                                 |  |  |  |   | 19 WAS AUTOPSY PERFORMED?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                                 | 20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)  |  |  |   |  |  |
| 20c TIME OF INJURY Month, Day, Year<br>Hour o m p.m. <b>19</b>   |                                 | 20d INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |  | 20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |   | 20f (City or town) (County) (State)  |  |
| 21 I certify that (X) (this hospital) attended the deceased from <b>12/4/</b> , 19 <b>67</b> , to <b>12/31/</b> , 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>12/31/</b> 19 <b>67</b> , and that death occurred at <b>9:15AM</b> from causes and on the date stated above.  |                                 |  |  |  |   |  |  |
| 22a SIGNATURE<br><b>Jose A. Raquel Jr. M.D.</b>  |                                 |  |  | M.D. ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/> |   | 22b DATE SIGNED  |  |
| 22c PHYSICIAN'S NAME (Type)<br><b>JOSE A. RAQUEL, JR. M.D.</b>   |                                 |  |  | 22d ADDRESS<br><b>VA HOSPITAL, FORT HOWARD, MARYLAND</b>   |   |  |  |
| 23a BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |                                 | 23b DATE THEREOF<br><b>1/5/68.</b>   |  | 23c NAME OF CEMETERY OR CREMATORY<br><b>Miami Memorial Cemetery</b>  |   | 23d LOCATION (City or Town) (County) (State)<br><b>Miami, Florida</b>                            |  |
| 24. FUNERAL DIRECTOR<br><b>Leonard J. Ruck Inc.</b>  |                                 |  |  | 25a REC'D BY REGISTRAR<br><b>JAN 4 1968</b>  |   | 25b REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>  |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

16610

16610

|   |  |  |  |  |  |  |  |
|---|--|--|--|--|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Baltimore</u> MARYLAND  |  |  |  | 2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission)<br>a. STATE <u>Maryland</u> b. COUNTY  |  |  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Catonsville</u>  |  |  |  | c. LENGTH OF STAY IN 1b  |  |  |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><u>Shady-Nook Nursing Home</u>  |  |  |  | d. STREET ADDRESS<br><u>51 Overbrook Rd.</u>   |  |  |  |
| e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |  |  |  |  |  |  |
| 3. NAME OF DECEASED (Type or print)<br>First <u>Augusta</u> Middle <u>Morfoot</u> Last  |  |  |  | 4. DATE OF DEATH<br>Month <u>Dec.</u> Day <u>7</u> Year <u>67</u>  |  |  |  |
| 5. SEX<br><u>F</u>  |  | 6. COLOR OR RACE<br><u>Cauc.</u>         |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><u>3/5/87</u>  |  |
| 9. AGE (In years lost birthday)<br><u>80</u> yrs  |  | IF UNDER 1 YEAR<br>Months Days Hours Min |  | IF UNDER 24 HRS<br>Months Days Hours Min   |  |  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>housewife</u>   |  |  |  | 10b. KIND OF BUSINESS OR INDUSTRY  |  | 11. BIRTHPLACE (County & State, or foreign country)<br><u>Maryland</u>                   |  |
| 12. CITIZEN OF WHAT COUNTRY?<br><u>USA</u>  |  |  |  |  |  |  |  |
| 13. FATHER'S NAME<br><u>---Jentner</u>  |  |  |  | 14. MOTHER'S MAIDEN NAME   |  |  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)   |  |  |  | 16. SOCIAL SECURITY NO   |  | 17. INFORMANT<br><u>Mr. Robert M. Morfoot, Jr.</u><br><u>4110 Steechwood Rd. - 21222</u> |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>4331</u><br>DUE TO <u>Cardiac arrhythmia</u><br>(b) <u>Arteriosclerotic Myocardial Degeneration</u><br>DUE TO <u>Generalized arteriosclerosis</u><br>(c) <u>lost</u> |  |  |  |  |  |  |  |
| INTERVAL BETWEEN ONSET AND DEATH  |  |  |  |  |  |  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |  |  |  |  |  |  |  |
| 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |  |  |  |  |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  |  | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)  |  |  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m. <u>19</u>  |  |  |  | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Not While <input type="checkbox"/><br>at work at work   |  | 20e. PLACE OF INJURY (Home, farm, factory street, office bldg., etc.)                    |  |
| 20f. (City or town) (County) (State)  |  |  |  |  |  |  |  |
| 21. I certify that (I) (this hospital) attended the deceased from <u>June</u> , 19 <u>67</u> , to <u>7 Dec</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>7 Dec</u> 19 <u>67</u> , and that death occurred at <u>11:30 AM</u> , from causes and on the date stated above.     |  |  |  |  |  |  |  |
| 22a. SIGNATURE<br><u>William J. Bryson</u>  |  |  |  | M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>                                      |  | 22b. DATE SIGNED<br><u>8 Dec 67</u>  |  |
| 22c. PHYSICIAN'S NAME (Type)<br><u>William J. Bryson</u>  |  |  |  | 22d. ADDRESS<br><u>4605 Edmondson Av.</u>  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)   |  | 23b. DATE THEREOF<br><u>12/9/67</u>      |  | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Western Cemetery</u>  |  | 23d. LOCATION (City or Town) (County) (State)<br><u>Baltimore, Md.</u>                   |  |
| 24. FUNERAL DIRECTOR<br><u>Witzke F. D. - 4101 Edmondson Av.</u>  |  |  |  | 25a. REC'D BY REGISTRAR<br><u>DEC 11 1967</u>  |  | 25b. REGISTRAR'S SIGNATURE<br><u>Charles Judge</u>                                       |  |



13  
(13)  
13



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17907

|  |        |                              |   |  |                      |  |  |  |   |
|--|--------|------------------------------|---|--|----------------------|--|--|--|---|
| DECEASED NAME<br>(Type or Print)   |        |                              | First   | Middle   | Last                 | 2a. DATE KNOWN OF DEATH<br>Month Day Year  |  |  | 2b. HOUR                                      |
| JAMES JOSEPH MORRIS  |        |                              |   |  |                      | 12/18 19 67  |  |  | 7:30 A.M.                                     |
| 3 SEX  | 4 RACE | 5. DATE OF BIRTH             | 6 AGE (In years last birthday)  | IF UNDER 1 YEAR<br>MONTHS DAYS   |                      | IF UNDER 24 HRS<br>HOURS MIN   |  | 2c. DATE PRONOUNCED DEAD<br>Month Day Year |   |
| Male   | White  | 1/5/34                       | 33 YRS  |  |                      |  |  | December 18, 19 67                         |   |
| 7a. BIRTHPLACE (State or foreign country)  |        | 7b. CITIZEN OF WHAT COUNTRY? |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                      | 9. COUNTY OF DEATH   |  |  |   |
| N.Y. City  |        | U.S.A.                       |   |  |                      | Baltimore Md   |  |  |   |
| 1d. CITY OR TOWN OF DEATH  |        |                              | 11. NAME OF HOSPITAL OR INSTITUTION (If not a hospital give street address)               |  |                      | 12a. USUAL OCCUPATION (Kind of work done during usual of working life, even if retired.)                     |  |  | 12b. KIND OF BUSINESS OR INDUSTRY             |
| Towson   |        |                              | Towson Police Station   |  |                      |  |  |  |   |
| 13a. USUAL RESIDENCE (Where deceased lived if institution. Residence before admission) STATE   |        |                              | 13b. COUNTY   |  | 13c. CITY OR TOWN    | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>              |  | 13e. STREET AND NUMBER                     |   |
| Maryland   |        |                              | V   |  | Baltimore            |  |  | 805 William Street                         |   |
| 14. FATHER'S NAME  |        |                              | First   | Middle   | Last                 | 15. MOTHER'S MAIDEN NAME   |  |  | First Middle Last                             |
| James J. Morris  |        |                              |   |  |                      | Mary Ellen Rush  |  |  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown)  |        |                              | 16b. SOCIAL SECURITY NO<br>(If yes give war or dates of service)                          |  | 17 INFORMANT ADDRESS |  |  |  |   |
|  |        |                              |   |  |                      |  |  |  |   |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Hanging</u><br>953x<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(b)<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)   |        |                              |   |  |                      |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br>974:   |        |                              |   |  |                      |  |  |  |   |
| 19a. DATE OF OPERATION   |        |                              | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |  |                      | 2D. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                          |  |  |   |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |        |                              | 21b. TIME OF INJURY Month, Day, Year<br>HOUR AM<br>6:15 PM 12/18/67                       |  |                      | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 18)<br>Subj. hung himself in jail |  |  |   |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK  |        |                              | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)<br>jail cell |  |                      | 21f. LOCATION Street or R.F.D. No City or Town County State<br>Towson Baltimore, Md.                         |  |  |   |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |        |                              |   |  |                      |  |  |  |   |
| ACTUAL SIGNATURE<br>Werner U. Spitz, M.D.  |        |                              | CHIEF MEDICAL EXAMINER <input type="checkbox"/>   |  |                      | 22b. DATE SIGNED<br>3/8/68   |  |  |   |
| EXAMINER'S NAME (Type)   |        |                              | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>                               |  |                      | ADDRESS (Street, city, town, or county)  |  |  |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)  |        |                              | 23b. DATE   |  |                      | 23c. NAME OF CEMETERY OR CREMATORY   |  |  | 23d. LOCATION (City or Town) (County) (State) |
| Burial   |        |                              | 12/27/67  |  |                      | Mt. Carmel   |  |  | 5700 O'Donnell St.                            |
| 24. FUNERAL DIRECTOR   |        |                              | ADDRESS   |  |                      | 25a. REC'D BY REGISTRAR  |  | 25b. REGISTRAR'S SIGNATURE                 |   |
| T. Fisher  |        |                              | 1930 Eastern Ave.   |  |                      | MAR 15 1968  |  |  |   |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

16618

16618

|   |                                 |  |  |
|---|---------------------------------|--|--|
| 1 PLACE OF DEATH<br>a. COUNTY <b>BALTIMORE</b><br>MARYLAND  |                                 | 2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)<br>a. STATE <b>MARYLAND</b><br>b. COUNTY <b>ANNE ARUNDEL</b>           |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>FORT HOWARD</b>  |                                 | c. LENGTH OF STAY IN 1b<br><b>179 DAYS</b>   |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>VETERANS ADMINISTRATION HOSPITAL</b>   |                                 | d. STREET ADDRESS<br><b>1430 ANNAPOLIS ROAD</b>  |  |
| 3 NAME OF DECEASED<br>(Type or print)<br>First <b>WILLIAM</b> Middle <b>R.</b> Last <b>MORRISON</b>   |                                 | 4 DATE OF DEATH<br>Month <b>DECEMBER</b> Day <b>10</b> Year <b>19 67</b>   |  |
| 5 SEX<br><b>MALE</b>  | 6 COLOR OR RACE<br><b>WHITE</b> | 7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8 DATE OF BIRTH<br><b>MARCH 22, 1920</b> |
| 9 AGE (In years lost birthday)<br><b>47</b> yrs   |                                 | 10 IF UNDER 1 YEAR<br>Months Days Hours Min  |  |
| 10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>LANDSCAPER HELPER</b>  |                                 | 10b KIND OF BUSINESS OR INDUSTRY<br><b>LANDSCAPER</b>  |  |
| 11 BIRTHPLACE (County & State, or foreign country)<br><b>DRURY, MARYLAND</b>  |                                 | 12 CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  |
| 13. FATHER'S NAME<br><b>HARRY MORRISON</b>  |                                 | 14 MOTHER'S MAIDEN NAME<br><b>MINA ALLISON</b>   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no or unknown) (If yes give year or dates of service)<br><b>YES PL 28</b>  |                                 | 16 SOCIAL SECURITY NO<br><b>216 18 54 98</b>   |  |
| 17 INFORMANT<br><b>CLIN. RECORDS, VA HOSPITAL, FT HOWARD, MD.</b>   |                                 | Address  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>BRONCHOPNEUMONIA</b><br><b>491X</b><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) <b>GLIOMA OF BRAIN</b><br>(c) |                                 | INTERVAL BETWEEN ONSET AND DEATH<br><b>RECENT</b>  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)  |                                 | 19 WAS AUTOPSY PERFORMED?<br><b>YES</b> <input checked="" type="checkbox"/> <b>NO</b> <input type="checkbox"/>   |  |
| 20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)   |                                 | 20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m. <b>19</b>  |                                 | 20d INJURY OCCURRED<br>While <input type="checkbox"/> Not While <input type="checkbox"/><br>at work at work  |  |
| 20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |                                 | 20f (City or town) (County) (State)  |  |
| 21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>6/14/67</b> , 19__, to <b>12/10/67</b> , 19__, that (a) (we) last saw the deceased alive on <b>12/10/67</b> , 19__, and that death occurred at <b>11:30 PM</b> from causes and on the date stated above.           |                                 |  |  |
| 22a SIGNATURE<br><i>Peter V. Juvan</i>  |                                 | 22b DATE SIGNED<br><b>12/11/67</b>   |  |
| 22c PHYSICIAN'S NAME (Type)<br><b>PETER V. JUWAN, M. D.</b>   |                                 | 22d. ADDRESS<br><b>VAH FORT HOWARD, MARYLAND</b>   |  |
| 23a BURIAL, CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>   |                                 | 23b. DATE THEREOF<br><b>12/14/67</b>   |  |
| 23c NAME OF CEMETERY OR CREMATORY<br><b>GLEN HAVEN MEMORIAL</b>   |                                 | 23d. LOCATION (City or Town) (County) (State)<br><b>GLEN BURNIE, MD.</b>   |  |
| 24. FUNERAL DIRECTOR<br><i>Robert P. Juvan</i>  |                                 | 25a REC'D BY REGISTRAR<br><b>DATE DEC 12 1967</b>  |  |
|   |                                 | 25b REGISTRAR'S SIGNATURE<br><i>Robert P. Juvan</i>  |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

16619

16612

|  |  |  |  |
|--|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Baltimore</b><br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b><br>c. LENGTH OF STAY IN 1b <b>27yrlmthldy</b><br>d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>SPRING GROVE STATE HOSPITAL+</b>                                       |  | 2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)<br>a. STATE <b>Maryland</b><br>b. COUNTY <b>Baltimore</b><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b><br>d. STREET ADDRESS <b>103 East 25th Street</b><br>e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |
| 3. NAME OF DECEASED (Type or print) <b>Anna Mortimer</b><br>First Middle Last<br>4. DATE OF DEATH <b>December 11 1967</b><br>Month Day Year  |  | 5. SEX <b>female</b><br>6. COLOR OR RACE <b>white</b><br>7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/><br>8. DATE OF BIRTH <b>10-21-86</b><br>9. AGE (In years last birthday) <b>81</b><br>IF UNDER 1 Year Months Days Hours Min.  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>saleslady</b><br>10b. KIND OF BUSINESS OR INDUSTRY<br>11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b><br>12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>   |  | 13. FATHER'S NAME <b>Sigmund Dengler</b><br>14. MOTHER'S MAIDEN NAME <b>Catherine Hergle</b>   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b><br>16. SOCIAL SECURITY NO.<br>17. INFORMANT <b>Records: SPRING GROVE STATE HOSPITAL</b><br>Address   |  | 18. CAUSE OF DEATH (Enter on any one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage or Infarction</b><br>DUE TO (b) <b>Cerebral Arteriosclerosis</b><br>DUE TO (c) <b>Arteriosclerosis, Generalized, Senile</b><br>CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>INTERVAL BETWEEN ONSET AND DEATH<br><b>12 hours</b><br><b>20 years</b><br><b>20 years</b>  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br><b>none except Arteriosclerotic cardiovascular Ht. Dis.</b><br>19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)<br>20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)<br>20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19<br>20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work<br>20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)<br>20f. (City or town) (County) (State) |  |
| 21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>Nov. 10</b> , 19 <b>67</b> to <b>Dec. 11</b> , 19 <b>67</b> , that <input checked="" type="checkbox"/> (we) lost the deceased alive on <b>Dec. 11</b> , 19 <b>67</b> , and that death occurred at <b>8:45</b> M, from causes and on the date stated above |  |  |  |
| 22a. SIGNATURE <b>Anthony J. Young, M.D.</b><br>22c. PHYSICIAN'S NAME (Type)<br>22b. DATE SIGNED <b>12-11-67</b><br>22d. ADDRESS <b>SPRING GROVE STATE HOSPITAL Baltimore, Maryland 21228</b>  |  | 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b><br>23b. DATE THEREOF <b>12/14/67</b><br>23c. NAME OF CEMETERY OR CREMATORY <b>Holy Redeemer Cemetery</b><br>23d. LOCATION (City or Town) (County) (State) <b>Baltimore, Md.</b>   |  |
| 24. FUNERAL DIRECTOR <b>Ulrich Funeral Home 4210 Belair Road.</b><br>ADDRESS<br>25a. REC'D BY REGISTRAR <b>DEC 15 1967</b><br>DATE<br>25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>  |  |  |  |



CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

|  |   |  |   |
|--|---|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Baltimore</b><br>MARYLAND  |   | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)<br>a. STATE <b>Maryland</b><br>b. COUNTY                           |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)   |   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Baltimore</b>   |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>St. Joseph Hospital</b>   |   | d. STREET ADDRESS<br><b>1032 Deanwood Road, 21234</b>  |   |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Baby</b> Middle <b>Girl</b> Last <b>MUIR</b>   |   | 4. DATE OF DEATH<br>Month <b>December</b> Day <b>16</b> Year <b>19 67</b>  |   |
| 5. SEX<br><b>Female</b>  | 6. COLOR OR RACE<br><b>White</b>  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>12-16-67</b>   |
| 9. AGE (In years last birthday)<br>yrs   |   | IF UNDER 1 YEAR<br>Months Days<br>IF UNDER 24 HRS<br>Hours Min<br><b>30</b>  |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)  |   | 10b. KIND OF BUSINESS OR INDUSTRY  |   |
| 11. BIRTHPLACE (County & State or foreign country)<br><b>Baltimore</b>   |   | 12. CITIZEN OF WHAT COUNTRY?   |   |
| 13. FATHER'S NAME<br><b>William Muir</b>   |   | 14. MOTHER'S MAIDEN NAME<br><b>Marguerite R. Mitchell</b>  |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)  |   | 16. SOCIAL SECURITY NO.  |   |
| 17. INFORMANT  |   | Address  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Immaturity</b><br>DUE TO<br>(b)<br>DUE TO<br>(c)<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last              |   |  | INTERVAL BETWEEN ONSET AND DEATH  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |   |  | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)  |   |
| 20c. TIME OF INJURY Month Day Year<br>Hour a.m. p.m. <b>19</b>   | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   | 20f. (City or town) (County) (State)  |
| 21. I certify that (I) (this hospital) attended the deceased from <b>12-16</b> , 19 <b>67</b> , to <b>12-16</b> , 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>12-16</b> , 19 <b>67</b> , and that death occurred at <b>12:25 p.m.</b> from causes and on the date stated above. |   |  |   |
| 22a. SIGNATURE<br><i>Jose A. Aguto</i>   |   | 22b. DATE SIGNED<br><b>12-16-67</b>  |   |
| 22c. PHYSICIAN'S NAME (Type)<br><b>Jose A. Aguto</b>   |   | 22d. ADDRESS<br><b>7620 York Road, Baltimore, Md. 21204</b>  |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)  | 23b. DATE THEREOF<br><b>5-17-68</b>   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Grave of Mt. Mary School</b>  | 23d. LOCATION (City or Town) (County) (State)<br><b>Baltimore, Md.</b>                            |
| 24. FUNERAL DIRECTOR   |   | 25a. REC'D BY REGISTRAR<br>DATE <b>MAY 20 1968</b>   |   |
|  |   | 25b. REGISTRAR'S SIGNATURE<br><i>James Judge</i>   |   |





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

VR A15 (4)  
25M 1/67

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (pages 1 and 2) and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH  |  |                                     |  |  |   |  |  |   |  |
|--|--|-------------------------------------|--|--|---|--|--|---|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |                                     |  |  |   |  |  |   |  |
| CERTIFICATE OF DEATH   |  |                                     |  |  |   |  |  |   |  |
| 1 PLACE OF DEATH<br>a. COUNTY <b>Baltimore</b> MARYLAND  |  |                                     |  |  | 2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY              |  |  |   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Lutherville, Maryland</b>   |  |                                     | c. LENGTH OF STAY IN 1b<br><b>2yrs; 1mo; 20days;</b> |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Baltimore City</b>                               |  |  |   |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>College Manor, Lutherville, Maryland</b>  |  |                                     |  |  | d. STREET ADDRESS<br><b>14 W. Cold Spring Lane, Balto, 10</b>   |  |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 3 NAME OF DECEASED (Type or print)<br>First Middle Last<br><b>IDA HAYES MULLINIX</b>   |  |                                     |  |  | 4 DATE OF DEATH<br>Month Day Year<br><b>DECEMBER 5th, 1967</b>  |  |  |   |  |
| 5 SEX<br><b>Female</b>   |  | 6 COLOR OR RACE<br><b>White</b>     |  | 7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 8. DATE OF BIRTH<br><b>9-15-1876</b>                                   |  | 9 AGE (In years last birthday) yrs<br><b>91</b>   |  |
| 10a. US. AL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housewife</b>   |  |                                     | 10b. KIND OF BUSINESS OR INDUSTRY                    |  | 11. BIRTHPLACE (County & State, or foreign country)<br><b>Montgomery County, Maryland</b>   |  |  | 12 CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  |
| 13. FATHER'S NAME<br><b>Julius Augustus Crockett</b>   |  |                                     |  |  | 14. MOTHER'S MAIDEN NAME<br><b>Mary Margaret Watkins</b>  |  |  |   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><b>No</b>   |  |                                     | 16. SOCIAL SECURITY NO.<br><b>212-01-9835</b>        |  | 17. INFORMANT<br><b>Mrs. Helen Parrish</b> Address<br><b>21 Turdock Rd. - 21212</b>   |  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Coronary decompensation</b><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>Arteriosclerotic cardiovascular disease</b><br>DUE TO<br>(c) <b>Arteriosclerosis, general</b> |  |                                     |  |  |   |  |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>5 yrs.</b><br><b>15 yrs.</b>                               |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br><b>Senile dementia</b>  |  |                                     |  |  |   |  |  | 19 WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>             |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |                                     |  | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)   |   |  |  |   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m.<br><b>19</b>  |  |                                     |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>  |   | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) |  | 20f. (City or town) (County) (State)  |  |
| 21 I certify that (I) (this hospital) attended the deceased from <b>Nov. 26, 1967</b> , to <b>Dec. 5, 1967</b> , that (I) (we) last saw the deceased alive on <b>Nov. 26, 1967</b> , and that death occurred at <b>1:45 P.M.</b> from causes and on the date stated above.   |  |                                     |  |  |   |  |  |   |  |
| 22a. SIGNATURE<br><b>Charles Eugene Howard</b> M.D.  |  |                                     |  |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  |  | 22b. DATE SIGNED  |  |
| 22c. PHYSICIAN'S NAME (Type)<br><b>Charles Eugene Howard</b>   |  |                                     |  |  | 22d. ADDRESS<br><b>12 E. Egan St., Balt.</b>  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |  | 23b. DATE THEREOF<br><b>12/8/67</b> |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>woodlawn Cemetery</b>   |   |  | 23d. LOCATION (City or town) (County) (State)<br><b>Baltimore, Md.</b> |   |  |
| 24 FUNERAL DIRECTOR<br><b>Witzke's Funeral Home</b> ADDRESS<br><b>4101 Edmonson Ave</b>  |  |                                     |  |  | 25a. REC'D BY REGISTRAR<br>DATE <b>DEC 7 1967</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>                     |   |  |



## CERTIFICATE OF DEATH

16614

16621

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

|   |  |   |  |
|---|--|---|--|
| 1 PLACE OF DEATH<br>a COUNTY <u>Balto.</u> MARYLAND   |  | 2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)<br>a STATE <u>Md.</u> b. COUNTY <u>Balto.</u>                          |  |
| b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Cockeysville</u>  |  | c LENGTH OF STAY IN IS<br><u>14 yrs 2 days</u>  |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><u>Md. Masonic Home</u>   |  | d. STREET ADDRESS<br><u>1729 Wilkins Ave</u>  |  |
| 3 NAME OF DECEASED<br>(Type or print)<br><u>Mary Manetta Murr</u>   |  | 4. DATE OF DEATH<br>Month <u>12</u> Day <u>10</u> Year <u>1967</u>  |  |
| 5 SEX<br><u>F</u>   | 6 COLOR OR RACE<br><u>W</u>  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8 DATE OF BIRTH<br><u>10-13-1890</u>                               |
| 9. AGE (In years lost birthday)<br><u>77</u> yrs  |  | 10a USUA. OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Seamstress</u>   |  |
| 10b KIND OF BUSINESS OR INDUSTRY<br><u></u>   |  | 11 BIRTHPLACE (County & State, or foreign country)<br><u>Balto. Md.</u>   |  |
| 13. FATHER'S NAME<br><u>Robert Thomas Harris</u>  |  | 14. MOTHER'S MAIDEN NAME<br><u>Mary Elizabeth Gittings</u>  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) (If yes give war or dates of service)<br><u>No</u>   |  | 16 SOCIAL SECURITY NO<br><u>None</u>  |  |
| 17 INFORMANT<br><u>Masonic Home Records.</u>  |  | Address   |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <u>4 Cerebrovascular accident Lt</u><br>DUE TO <u>right hemiplegia</u><br>(b) <u>3 Generalized arteriosclerosis</u><br>DUE TO <u>3, Von Recklinghausen disease</u><br>(c) <u>3, Von Recklinghausen disease</u> |  | INTERVAL BETWEEN ONSET AND DEATH  |  |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |  |   |  |
| 20a ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)  |  |
| 20c TIME OF INJURY Month, Day, Year<br>Hour a.m. _____ p.m. <u>19</u>   | 20d INJURY OCCURRED<br>While <input type="checkbox"/> at work <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> | 20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   | 20f (City or town) (County) (State)                                |
| 21. I certify that (I) (this hospital) attended the deceased from <u>August</u> , 1965, to <u>Dec 8</u> , 1967, that (I) (we) lost saw the deceased alive on <u>Dec 8</u> , 1967, and that death occurred at <u>1:39 AM</u> , from causes and on the date stated above.   |  |   |  |
| 22a SIGNATURE<br><u>JAMES H. HAMEL MD</u>   |  | 22b DATE SIGNED<br><u>12/10/67</u>  |  |
| 22c PHYSICIAN'S NAME (Type)<br><u>JAMES H. HAMEL MD</u>   |  | 22d ADDRESS<br><u>MASSONIC HOME Cockeysville</u>  |  |
| 23a BURIAL, CREMATION, REMOVAL (Specify)<br><u>BURIAL</u>   | 23b DATE THEREOF<br><u>DEC. 13, 1967</u>   | 23c NAME OF CEMETERY OR CREMATORY<br><u>Woodlawn Cemetery</u>   | 23d LOCATION (City or town) (County) (State)<br><u>Woodlawn Md</u> |
| 24 FUNERAL DIRECTOR<br><u>Wm Cook-Brooks Towson</u>   |  | 25a REC'D BY REG STRAR<br><u>1050 York Road Towson, Md</u>  |  |
| 25b REGISTRAR'S SIGNATURE<br><u>J. J. Judge</u>   |  | DATE<br><u>DEC 13 1967</u>  |  |



CERTIFICATE OF DEATH

16615

16622

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

|  |  |  |  |
|--|--|--|--|
| 1 PLACE OF DEATH<br>a. COUNTY <b>Baltimore</b><br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b><br>c. LENGTH OF STAY IN It<br>d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>1301 Black Friars Rd.</b>  |  | 2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)<br>a. STATE <b>Maryland</b><br>b. COUNTY <b>Baltimore</b><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b><br>d. STREET ADDRESS <b>1301 Black Friars Rd.</b><br>e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 3 NAME OF DECEASED (Type or print)<br>First <b>Nova E.</b> Middle <b>Murray</b> Last<br>5 SEX <b>F</b> 6. COLOR OR RACE <b>Cauc.</b> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> B. DATE OF BIRTH <b>7/10/1891</b> 9. AGE (In years last birthday) <b>76</b> yrs<br>10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House wife</b> 10b. KIND OF BUSINESS OR INDUSTRY<br>11. BIRTHPLACE (County & State or foreign country) <b>Balto., Md.</b> 12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b> |  | 4 DATE OF DEATH<br>Month <b>Dec.</b> Day <b>30</b> Year <b>67</b><br>IF UNDER 1 YEAR Months Days Hours Min<br>IF UNDER 24 HRS  |  |
| 13. FATHER'S NAME <b>Late Daniel W. Myer</b>   |  | 14. MOTHER'S MAIDEN NAME   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)  |  | 16. SOCIAL SECURITY NO   |  |
| 17. INFORMANT <b>Mr. John Murray</b> Address <b>1301 Black Friars Rd. Catonsville, Md.</b>   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).)<br>PART I. DEATH WAS CAUSED BY.<br>IMMEDIATE CAUSE (a) <b>1991</b><br>DUE TO <b>Sarcoma, left arm</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>6 yrs.</b><br>DUE TO<br>(c)   |  | INTERVAL BETWEEN ONSET AND DEATH   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)<br><b>P.S.C.V. disease, Hypertension</b>  |  | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. pm 19  |  | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work   |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |  | 20f. (City or town) (County) (State)   |  |
| 21. I certify that (I) (this hospital) attended the deceased from <b>July 1967</b> , to <b>Dec. 30, 1967</b> , that (I) (we) last saw the deceased alive on <b>Dec. 28, 1967</b> , and that death occurred at <b>3:25 PM</b> , from causes and on the date stated above.   |  |  |  |
| 22a. SIGNATURE <b>D.C. MacLaughlin</b> M.D.  |  | 22b. DATE SIGNED <b>1/2/68</b>   |  |
| 22c. PHYSICIAN'S NAME (Type) <b>D. C. MacLaughlin</b>  |  | 22d. ADDRESS <b>303 N. Rolling Road</b>  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>  |  | 23b. DATE THEREOF <b>1/3/68</b>  |  |
| 23c. NAME OF CEMETERY OR CREMATORY <b>Lorraine Park Cemetery</b>   |  | 23d. LOCATION (City or Town) (County) (State) <b>Balto., Md.</b>   |  |
| 24. FUNERAL DIRECTOR <b>Witzke F. D. - 4101 Edmondson Ave. Balto., Md. 21229</b>   |  | 25a. REC'D BY REGISTRAR <b>JAN 3 1968</b> 25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>  |  |



# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PMS-Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

16623

10616

|   |   |  |   |
|---|---|--|---|
| 1 PLACE OF DEATH<br>a. COUNTY<br><b>Baltimore</b><br>MARYLAND   |   | 2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission)<br>a. STATE<br><b>Maryland</b><br>b. COUNTY  |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Towson</b>   |   | c. LENGTH OF STAY IN 1b<br><b>Baltimore</b>  |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>St. Joseph's Hospital</b>  |   | e. STREET ADDRESS<br><b>4247 Shamrock Avenue</b><br>e. RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |   |
| 3. NAME OF DECEASED<br>(Type or print)<br><b>WALTER LOUIS MYERS, Jr.</b>  |   | 4. DATE OF DEATH<br>Month <b>December</b> Day <b>18</b> Year <b>1967</b>   |   |
| 5. SEX<br><b>Male</b>   | 6. COLOR OR RACE<br><b>White</b>  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>  | 8. DATE OF BIRTH<br><b>May 27, 1934</b>   |
| 9. AGE (in years last birthday)<br><b>33 yrs.</b>   |   | 10. UNDER 24 HRS<br>Months Days Hours Min  |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Contractor,</b>   |   | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Home Improvement</b>   |   |
| 11. BIRTHPLACE (State or foreign country)<br><b>Baltimore, Md.</b>  |   | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |   |
| 13. FATHER'S NAME<br><b>Walter L. Myers, Sr.,</b>   |   | 14. MOTHER'S MAIDEN NAME<br><b>Mary Scharnagle</b>   |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><b>Yes 1951-1955</b>   |   | 16. SOCIAL SECURITY NO.<br><b>213-30-4465</b>  |   |
| 17. INFORMANT<br><b>Walter L. Myers, Sr.</b>  |   | Address<br><b>4247 Shamrock Ave.</b>   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Arteriosclerotic Cardiovascular Disease</b><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) <b>4221</b><br>(c)  |   |  | INTERVAL BETWEEN ONSET AND DEATH  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |   |  | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)  |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m. <b>19</b>  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (home, farm, factory, street, office bldg., etc.)   | 20f. (City or town) (County) (State)  |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspect on <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from <u>Natural causes</u> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |   |  |   |
| ACTUAL SIGNATURE<br><b>Werner U. Spitz, M.D.</b><br>EXAMINER'S NAME (Type)  |   | 22. DATE SIGNED<br><b>12/19/67</b><br>CHIEF MEDICAL EXAMINER <input type="checkbox"/><br>ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/><br>DEPUTY MEDICAL EXAMINER <input type="checkbox"/><br>Address (Street, city, town, or county) |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  | 23b. DATE THEREOF<br><b>12/21/67</b>  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Baltimore National Cemetery</b>   | 23d. LOCATION (City or town) (County) (State)<br><b>Baltimore, Md.</b>              |
| 24. FUNERAL DIRECTOR<br><b>Ullrich Funeral Home 4210 Belair Road.</b>   |   | 25a. REC'D BY REGISTRAR<br><b>DEC 22 1967</b><br>DATE<br>25b. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>  |   |





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 M  
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

|   |   |   |   |
|---|---|---|---|
| 1 PLACE OF DEATH<br>a COUNTY <b>Baltimore,</b><br><b>CATONSVILLE</b><br>MARYLAND  |   | 2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a STATE <b>Maryland</b><br>b COUNTY                                 |   |
| b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Rural - Catonsville</b>   |   | c LENGTH OF STAY IN 1b<br><b>21 months</b>  |   |
| d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>SHAGRI - LA NURSING HOME</b>  |   | d STREET ADDRESS<br><b>614 S. Washington St. #21231</b>   |   |
| 3 NAME OF DECEASED<br>(Type or print) <b>VICTORIA</b> First <b>NADOLNY</b> Middle Last  |   | 4 DATE OF DEATH<br>Month <b>12</b> - Day <b>21</b> - Year <b>1967</b>   |   |
| 5. SEX<br><b>F</b>  | 6. COLOR OR RACE<br><b>W</b>  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>1889</b><br><b>November 29, 1889</b>                 |
| 10b. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housewife - Canner</b>  |   | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Packing House</b>   | 11. BIRTHPLACE (County & State, or foreign country)<br><b>Poland</b>        |
| 13. FATHER'S NAME<br><b>Frank Wiatrowski</b>  |   | 14. MOTHER'S MAIDEN NAME<br><b>Mary Cyganek</b>   |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) (If yes give war or dates of service)<br><b>No</b>   |   | 16. SOCIAL SECURITY NO<br><b>216-01-7019</b>  |   |
| 17. INFORMANT<br><b>Stanislaus Nadolny - 614 S. Washington St.</b>  |   | Address   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <b>Bronchopneumonia</b><br>DUE TO <b>Cachexia</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. }<br>DUE TO <b>Diabetes - Multiple Decubiti - Senility</b> |   |   | INTERVAL BETWEEN ONSET AND DEATH  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)  |   |   |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)  |   | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)   |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m. <b>19</b>  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  | 20f. (City or town) (County) (State)  |
| 21. I certify that (I) (this hospital) attended the deceased from <b>4-2-</b> , 1966, to <b>12-21-</b> , 1967, that (I) (we) last saw the deceased alive on <b>12-21-</b> , 1967, and that death occurred at <b>1A</b> M, from causes and on the date stated above.   |   |   |   |
| 22a. SIGNATURE<br><b>Cesar Valle Caverio</b>  |   | M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>                        | 22b. DATE SIGNED<br><b>12-21-67</b>   |
| 22c. PHYSICIAN'S NAME (Type)<br><b>CESAR VALLE CAVERIO</b>  |   | 22d. ADDRESS<br><b>8624 Liberty Rd</b>  |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  | 23b. DATE THEREOF<br><b>12/23/67</b>  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>St. Stanislaus</b>   | 23d. LOCATION (City or Town) (County) (State)<br><b>Baltimore, Maryland</b> |
| 24. FUNERAL DIRECTOR<br><b>George A. Weber - 705 S. Ann St. #21231</b>  |   | 25a. REC'D BY REGISTRAR<br>DATE <b>DEC 26 1967</b>  |   |
|   |   | 25b. REGISTRAR'S SIGNATURE<br><i>William J. Judge</i>   |   |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

16625

CERTIFICATE OF DEATH

16618

|  |  |  |  |
|--|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY<br><b>Baltimore</b><br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Towson</b><br>c. LENGTH OF STAY IN 1b<br><b>MARYLAND</b><br>d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>St. Joseph's Hospital</b>                                    |  | 2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission)<br>a. STATE<br><b>Maryland</b><br>b. COUNTY<br><b>Baltimore</b><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Towson</b><br>d. STREET ADDRESS<br><b>954 Dulaney Valley Road</b><br>e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 3. NAME OF DECEASED (Type or print)<br>First<br><b>Beulah</b><br>Middle<br><b>C.</b><br>Last<br><b>Naylor</b>  |  | 4. DATE OF DEATH<br>Month<br><b>12</b><br>Day<br><b>26</b><br>Year<br><b>1967</b>  |  |
| 5. SEX<br><b>F</b>   |  | 6. COLOR OR RACE<br><b>W</b>   |  |
| 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>  |  | 8. DATE OF BIRTH<br><b>2-20-1892</b>   |  |
| 9. AGE (In years last birthday)<br><b>75</b> yrs.  |  | 10. IF UNDER 1 YEAR<br>Months<br><b>7</b><br>Days<br><b>15</b><br>Hours<br><b>15</b><br>Min.   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Homemaker</b>  |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Own Home</b>   |  |
| 11. BIRTHPLACE (County & State, or foreign country)<br><b>Baltimore, Maryland</b>  |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  |
| 13. FATHER'S NAME<br><b>Levi Lee Chambers</b>  |  | 14. MOTHER'S MAIDEN NAME<br><b>Florence Hare</b>   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)<br><b>No</b>   |  | 16. SOCIAL SECURITY NO.<br><b>218-03-1856</b>  |  |
| 17. INFORMANT<br><b>Mrs. Marie C. Schaefer</b>   |  | Address<br><b>802 Mockingbird Lane</b>   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cerebral hemorrhage</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO (b) <b>Arteriosclerotic C.V.D.</b><br>DUE TO (c) <b>Rheumatic mitral disease</b> |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>Few hours</b><br><b>5 years</b><br><b>60 years</b>  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |  | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m.<br>p.m.<br><b>19</b>   |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>  |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |  | 20f. (City or town) (County) (State)   |  |
| 21. I certify that (I) (this hospital) attended the deceased from <b>Nov. 17, 1967</b> to <b>Dec. 26, 1967</b> , that (I) (we) last saw the deceased alive on <b>Nov. 17, 1967</b> , and that death occurred at <b>4:00 P.M.</b> from the causes and on the date stated above.   |  |  |  |
| 22a. SIGNATURE<br><b>Louis E. Wice</b>   |  | 22b. DATE SIGNED<br><b>12/28/67</b>  |  |
| 22c. PHYSICIAN'S NAME (Type)<br><b>Dr. Louis E. Wice</b>   |  | 22d. ADDRESS<br><b>920 St. Paul Street Balto., Md.</b>   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |  | 23b. DATE THEREOF<br><b>12-29-67</b>   |  |
| 23c. NAME OF CEMETERY OR CREMATORY<br><b>Woodlawn Cemetery</b>   |  | 23d. LOCATION (City, town or county) (State)<br><b>Baltimore, Co., Md.</b>   |  |
| 24. FUNERAL DIRECTOR<br><b>H. W. Jenkins &amp; Sons Co.</b>  |  | 25a. REC'D BY REGISTRAR<br><b>21212</b>  |  |
| 25b. REGISTRAR'S SIGNATURE<br><b>4905 York Rd. Balto., Md.</b>   |  | DATE <b>JAN 2 1968</b>   |  |



MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE  
HEALTH DEPT.

16626

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

16619

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

|   |   |  |   |
|---|---|--|---|
| 1 PLACE OF DEATH<br>a. COUNTY <u>Baltimore</u> MARYLAND   |   | 2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission)<br>a. STATE <u>MARYLAND</u> b. COUNTY <u>Baltimore</u>  |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>28228</u>   |   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CATONSVILLE, MARYLAND 21228</u>  |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>8 Wyndcrest Ave.</u>  |   | d. STREET ADDRESS <u>8 Wyndcrest Rd</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   |
| 3 NAME OF DECEASED (Type or print) <u>GWYNEDOLYN F. NEUMANN</u>   |   | 4 DATE OF DEATH <u>Dec. 9</u> 19 <u>67</u>   |   |
| 5 SEX <u>F</u>  | 6 COLOR OR RACE <u>W</u>  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>   | 8. DATE OF BIRTH <u>11/4/05</u> 9. AGE (In years, months, days) <u>62</u> yrs.                |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)   |   | 10b. KIND OF BUSINESS OR INDUSTRY  |   |
| 11 BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u>  |   | 12 CITIZEN OF WHAT COUNTRY? <u>USA</u>   |   |
| 13 FATHER'S NAME <u>Late- William Johnson</u>   |   | 14 MOTHER'S MAIDEN NAME <u>Gertrude Garner</u>   |   |
| 15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)  |   | 16 SOCIAL SECURITY NO.   |   |
| 17 INFORMANT <u>Mrs. Gladys Pfieffer</u> Address <u>12 S. Belle Grove Rd.</u>   |   |  |   |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))<br>PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>NATURAL CAUSES.</u><br>DUE TO (b) <u>CONDITIONS IF ANY WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST</u><br>(c)  |   |  | INTERVAL BETWEEN ONSET AND DEATH  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |   |  | 19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |   | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)   |   |
| 20c. TIME OF INJURY Month, Day, Year <u>19</u><br>Hour <u>am</u> or <u>pm</u>   | 20d. INJURY OCCURRED While <input type="checkbox"/> at work or Not While <input type="checkbox"/> at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office, etc.)   | 20f. ((City or town) (County) (State)   |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspect on <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |   |  |   |
| ACTUAL SIGNATURE <u>J. Nelson McKay</u> M.D.  |   | 22. DATE SIGNED <u>Dec 9, 1967</u>   |   |
| EXAMINER'S NAME (Type) <u>J. Nelson McKay</u>   |   | CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town or county) |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Entombment</u>   | 23b. DATE THEREOF <u>12/12/67</u>   | 23c. NAME OF CEMETERY OR CREMATORY <u>Lorraine Park Mausoleum</u>  | 23d. LOCATION (City or Town) (County) (State) <u>Baltimore, Md.</u>                           |
| 24. FUNERAL DIRECTOR <u>Witzke F. D. - 4101 Lamondson Ave.</u>  |   | 25a. REC'D BY REGISTRAR <u>DEC 14 1967</u>   | 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>   |



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE  
HEALTH DEPT

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

16625

16620

|   |   |  |   |
|---|---|--|---|
| 1 PLACE OF DEATH<br>a. COUNTY <b>Baltimore</b> MARYLAND   |   | 2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>                 |   |
| b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town)<br><b>Dundalk</b>   |   | c. LENGTH OF STAY IN 1b<br><b>Dundalk</b>  |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>Dunleer Apts.</b>  |   | d. STREET ADDRESS<br><b>Dunleer Apts,</b>  |   |
| 3 NAME OF DECEASED (Type or print)<br>First <b>Milton</b> Middle <b>L.</b> Last <b>Novotny</b>  |   | 4 DATE OF DEATH<br>Month <b>Dec.</b> Day <b>31,</b> Year <b>19 67</b>  |   |
| 5 SEX<br><b>Male</b>  | 6 COLOR OR RACE<br><b>White</b>   | 7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8 DATE OF BIRTH<br><b>Aug. 24, 1892</b> |
| 9 AGE (in years last birthday) yrs<br><b>75</b>   |   | F UNDER 1 YEAR Months Days F UNDER 24 HRS Hours Min  |   |
| 10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Tin mill</b>   |   | 10b KIND OF BUSINESS OR INDUSTRY<br><b>Steel</b>   |   |
| 11 BIRTHPLACE (State or foreign country)<br><b>Maryland</b>   |   | 12 CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |   |
| 13 FATHER'S NAME<br><b>John Novotny</b>   |   | 14 MOTHER'S MAIDEN NAME<br><b>?</b>  |   |
| 15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><b>Yes WW 1</b>   |   | 16 SOCIAL SECURITY NO<br><b>?</b>  |   |
| 17 INFORMANT<br><b>Mrs. Anna Goetz 7610 Bagley Ave.</b>   |   | Address  |   |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Myocardial infarction + A-S-C-V disease</b><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost }<br>(b) <b>Heart disease</b><br>DUE TO<br>(c) <b>Heart disease</b>  |   | INTERVAL BETWEEN ONSET AND DEATH<br><b>44</b>  |   |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |   | 19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |   |
| 20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |   | 20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)<br><b>None</b>   |   |
| 20c TIME OF INJURY Month, Day, Year<br>Hour a.m. <b>19</b> p.m.   | 20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  | 20f (City or town) (County) (State)     |
| 21. I certify that I took charge of the remains described above held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> |   |  |   |
| ACTUAL SIGNATURE<br><b>M.B. Davis</b>   |   | CHIEF MEDICAL EXAMINER <input type="checkbox"/>  |   |
| EXAMINER'S NAME (Type)<br><b>M.B. Davis, M.D.</b>   |   | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>  |   |
|   |   | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>  |   |
|   |   | Address (Street city town or county)<br><b>6800 Mornington Rd.</b>   |   |
| 23a BURIAL, CREMATION, REMAINS (Specify)<br><b>Burial</b>   |   | 23b DATE THEREOF<br><b>January 4, 68</b>   |   |
| 23c NAME OF CEMETERY OR CREMATORY<br><b>Baltimore National</b>  |   | 23d LOCATION (City or town) (County) (State)<br><b>Baltimore, Maryland</b>   |   |
| 24 FUNERAL DIRECTOR<br><b>Ullrich Funeral Home 4210 Belair Road.</b>  |   | 25a RECD BY REGISTAR<br><b>JAN 5 1968</b>  |   |
|   |   | 25b REGISTRAR'S SIGNATURE<br><b>Charles Jones</b>  |   |





## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15621

16623

FOR STATE  
HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

|  |                                  |   |  |
|--|----------------------------------|---|--|
| 1 PLACE OF DEATH<br>a. COUNTY<br><b>Baltimore</b><br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Essex (21)</b>   |                                  | 2 USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)<br>a. STATE<br><b>Maryland</b><br>b. COUNTY<br><b>Baltimore</b><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Essex (21)</b> |  |
| 3 NAME OF DECEASED<br>(Type or print)<br><b>HUBERT OWEN O'DAIR</b>   |                                  | 4 DATE OF DEATH<br><b>December 3 1967</b>   |  |
| 5. SEX<br><b>Male</b>  | 6. COLOR OR RACE<br><b>White</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>   | 8. DATE OF BIRTH<br><b>April 1, 1900</b> |
| 9. AGE (In years last birthday)<br><b>67 yrs</b>   |                                  | 10. F UNDER 1 YEAR<br>Months Days Hours Min   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired)<br><b>Machinist</b>   |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Steel Mill</b>  |  |
| 11. BIRTHPLACE (State or foreign country)<br><b>Illinois</b>   |                                  | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  |
| 13. FATHER'S NAME<br><b>Abe O'Dair</b>   |                                  | 14. MOTHER'S MAIDEN NAME  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><b>Yes WWI</b>  |                                  | 16. SOCIAL SECURITY NO.<br><b>213 09 3218</b>   |  |
| 17. INFORMANT<br><b>Dorothy Adair</b>  |                                  | Address<br><b>Same</b>  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).<br>PART I. DEATH WAS CAUSED BY<br><b>431 Acute Coronary Occlusion</b><br><b>HCD</b><br>IMMEDIATE CAUSE (a) DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) DUE TO<br>(c)   |                                  | INTERVAL BETWEEN ONSET AND DEATH  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |                                  |   |  |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.   |                                  | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m. 19  |                                  | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work  |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |                                  | 20f. (City or town) (County) (State)  |  |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> |                                  |   |  |
| ACTUAL SIGNATURE<br><b>Theodore C. Patterson</b>   |                                  | CHIEF MEDICAL EXAMINER <input type="checkbox"/>   |  |
| EXAMINER'S NAME (Type)<br><b>Theodore Patterson, M.D.</b>  |                                  | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>   |  |
| 23a. BURIAL CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |                                  | 23b. DATE THEREOF<br><b>12/6/67</b>   |  |
| 23c. NAME OF CEMETERY OR CREMATORY<br><b>Balto. National Cemetery</b>  |                                  | 23d. LOCATION (City or Town) (County) (State)<br><b>Baltimore, Md.</b>  |  |
| 24. FUNERAL DIRECTOR<br><b>Brudzinski Funeral Home</b>   |                                  | 25a. RECEIVED BY REG. STRAP<br><b>DEC 6 1967</b>  |  |
| 25b. REGISTRAR'S SIGNATURE<br><b>John J. Jones</b>   |                                  | 25c. REGISTRAR'S NAME<br><b>John J. Jones</b>   |  |



# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## CERTIFICATE OF DEATH

16621

10322

|  |   |  |  |
|--|---|--|--|
| 1 PLACE OF DEATH<br>a. COUNTY <u>BALTIMORE</u><br><u>SPRINGFIELD</u><br>MARYLAND   |   | 2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)<br>a. STATE <u>Maryland</u><br>b. COUNTY <u>Carroll</u>               |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Catonsville</u>   |   | c. LENGTH OF STAY IN 1b<br><u>3 years</u>  |  |
| c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Westminster</u>   |   | d. STREET ADDRESS<br><u>5500 York Road</u>   |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><u>SHANGRI-LA NURSING HOME</u>   |   | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |
| 3 NAME OF DECEASED (Type or print)<br><u>KATIE L. OGLE</u><br>First Middle Last  |   | 4 DATE OF DEATH<br><u>12-4-1967</u><br>Month Day Year  |  |
| 5 SEX<br><u>Female</u>   | 6. COLOR OR RACE<br><u>White</u>  | 7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8 DATE OF BIRTH<br><u>Aug. 26, 1906</u>  |
| 9 AGE (In years last birthday)<br><u>61</u> yrs.   |   | IF UNDER 1 YEAR<br>Months Days Hours Min.  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Domestic</u>   |   | 10b. KIND OF BUSINESS OR INDUSTRY  |  |
| 11. BIRTHPLACE (County & State, or foreign country)<br><u>Carroll Co., Md.</u>   |   | 12 CITIZEN OF WHAT COUNTRY?<br><u>United States</u>  |  |
| 13. FATHER'S NAME<br><u>Rezin Forver</u>   |   | 14. MOTHER'S MAIDEN NAME<br><u>Katie Holmes</u>  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><u>No</u>   |   | 16. SOCIAL SECURITY NO<br><u>218-50-6034</u>   |  |
| 17 INFORMANT<br><u>Mrs. Florine Cook</u>   |   | Address<br><u>Same as #2</u>   |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY.<br>IMMEDIATE CAUSE (a) <u>Shock</u><br>DUE TO (b) <u>Thrombosis of L. Iliac Artery</u><br>DUE TO (c) <u>and gangrene Entire L. Leg</u>                           |   |  | INTERVAL BETWEEN ONSET AND DEATH   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br><u>C.V.A. &amp; L. side emphysema</u>   |   |  | 19 WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |   | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m. <u>19</u>   | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)  | 20f. (City or town) (County) (State)   |
| 21. I certify that (I) (this hospital) attended the deceased from <u>1-5-</u> , 1966, to <u>11-4-</u> , 1967, that (I) (we) last saw the deceased alive on <u>12-4-</u> , 1967, and that death occurred at <u>3:25 PM</u> , from causes on and on the date stated above. |   |  |  |
| 22a. SIGNATURE<br><u>Cesar Valle Caverio</u>   |   | 22b. DATE SIGNED<br><u>12-4-67</u>   |  |
| 22c. PHYSICIAN'S NAME (Type)<br><u>CESAR VALLE CAVERO</u>  |   | 22d. ADDRESS<br><u>8024 Liberty Rd. Rockville, Md.</u>   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)  | 23b. DATE THEREOF<br><u>12/7/1967</u>   | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Taylorville Cemetery</u>  | 23d. LOCATION (City or Town) (County) (State)<br><u>Carroll Co., Md.</u>                         |
| 24. FUNERAL DIRECTOR<br><u>C. H. Woltz</u>   |   | 25a. REC'D BY REGISTRAR<br><u>DEC 7 1967</u>   |  |
| ADDRESS<br><u>241 J. J. Woltz, Jr., Md.</u>  |   | 25b. REGISTRAR'S SIGNATURE<br><u>Charles Judge</u>   |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (6)  
20 M 1/68



# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if any delay is necessary, please execute the certificate "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

16630

15623

|  |                                  |   |                                    |
|--|----------------------------------|---|------------------------------------|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Baltimore</b> MARYLAND   |                                  | 2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission)<br>a. STATE <b>West Virginia</b> b. COUNTY <b>C</b>                   |                                    |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Parsons</b>   |                                  | c. LENGTH OF STAY IN 1b   |                                    |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>66 Transverse Ave. 21220</b>  |                                  | d. STREET ADDRESS<br><b>234 Billings Ave.</b>   |                                    |
| 3. NAME OF DECEASED (Type or print)<br><b>CRESSIE</b> First <b>MAE</b> Middle <b>OLDAKER</b> Last  |                                  | 4. DATE OF DEATH<br>Month <b>12</b> Day <b>22</b> Year <b>'67</b>   |                                    |
| 5. SEX<br><b>Female</b>  | 6. COLOR OR RACE<br><b>White</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>6/13/98</b> |
| 9. AGE (In years lost birthday) yrs <b>69</b>  |                                  | 10. IF UNDER 1 YEAR Months Days Hours Min   |                                    |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housewife</b>  |                                  | 10b. KIND OF BUSINESS OR INDUSTRY   |                                    |
| 11. BIRTHPLACE (State or foreign country)<br><b>W. Virginia</b>  |                                  | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |                                    |
| 13. FATHER'S NAME<br><b>Baxter Shaffer</b>   |                                  | 14. MOTHER'S MAIDEN NAME<br><b>Lusendy Katherine - -</b>  |                                    |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><b>No</b>   |                                  | 16. SOCIAL SECURITY NO.<br><b>None</b>  |                                    |
| 17. INFORMANT<br><b>Dortha Mae Sanders, 66 Transverse Ave.</b>   |                                  | Address <b>21220</b>  |                                    |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <b>Acute Coronary Occlusion</b><br>DUE TO <b>AEVD</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b)<br>(c)<br>PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Diabetes mellitus</b> |                                  | INTERVAL BETWEEN ONSET AND DEATH  |                                    |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)   |                                    |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour <b>pm</b> <b>19</b>   |                                  | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>    |                                    |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |                                  | 20f. (City or town) (County) (State)  |                                    |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>    |                                  |   |                                    |
| ACTUAL SIGNATURE<br><b>Thos C. Patterson</b><br>EXAMINER'S NAME (Type)   |                                  | 22. DATE SIGNED<br><b>12/22/67</b>  |                                    |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |                                  | 23b. DATE THEREOF<br><b>12/24/67</b>  |                                    |
| 23c. NAME OF CEMETERY OR CREMATORY<br><b>Parsons City Cemetery</b>   |                                  | 23d. LOCATION (City or Town) (County) (State)<br><b>Parsons W. Va.</b>  |                                    |
| 24. FUNERAL DIRECTOR<br><b>Howard H. Hubbard Funeral Home, 4107 Wilkens Ave.</b>   |                                  | 25a. REC'D BY REGISTRAR<br><b>DATE 12-27-67</b>   |                                    |
| 25b. REGISTRAR'S SIGNATURE<br><b>James S. Judge</b>  |                                  |   |                                    |

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| <div style="text-align: center;"> <b>MARYLAND STATE DEPARTMENT OF HEALTH</b><br/> <b>DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</b><br/> <b>CERTIFICATE OF DEATH</b> </div>   |  |  |   |   |  |  |  |  |   |  |  |   |  |  |   |  |  |   |  |  |
|---|--|--|---|---|--|--|--|--|---|--|--|---|--|--|---|--|--|---|--|--|
| <b>1. PLACE OF DEATH</b><br>a. COUNTY <u>BALTIMORE</u> <span style="float: right;">16631</span><br>b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Towson</u><br>c. LENGTH OF STAY IN 1b <u>MARYLAND</u><br>d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>GREATER BALTIMORE Medical Center</u>  |  |  |   |   |  | <b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission)<br>a. STATE <u>MARYLAND</u> <span style="float: right;">10624</span><br>b. COUNTY <u>BALTIMORE</u><br>c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>KINGSVILLE 21087</u><br>d. STREET ADDRESS <u>MOHR RD.</u><br>e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |   |  |  |   |  |  |   |  |  |   |  |  |
| <b>3. NAME OF DECEASED</b> (Type or print)<br>First <u>ANDREW</u> Middle <u>JOHN</u> Last <u>PANZER, Sr.</u>  |  |  | <b>4. DATE OF DEATH</b><br>Month <u>December</u> Day <u>30</u> Year <u>1967</u> |   |  | <b>5. SEX</b><br><u>MALE</u>   |  |  | <b>6. COLOR OR RACE</b><br><u>CAUC.</u>   |  |  | <b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  | <b>8. DATE OF BIRTH</b><br><u>1-29-19</u> |  |  | <b>9. AGE</b> (In years last birthday) <u>48</u> yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. |  |  |
| <b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)<br><u>CARPENTER</u>  |  |  |   |   |  | <b>10b. KIND OF BUSINESS OR INDUSTRY</b><br>_____  |  |  | <b>11. BIRTHPLACE</b> (County & State, or foreign country)<br><u>BALTIMORE, MD.</u> |  |  | <b>12. CITIZEN OF WHAT COUNTRY?</b><br><u>UNITED STATES</u>   |  |  |   |  |  |   |  |  |
| <b>13. FATHER'S NAME</b><br><u>ANDREW PANZER</u>  |  |  |   |   |  | <b>14. MOTHER'S MAIDEN NAME</b><br><u>MARGARET STREHLER</u>  |  |  |   |  |  |   |  |  |   |  |  |   |  |  |
| <b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>YES</u> (If yes give war or dates of service) <u>1942-1946</u>  |  |  |   |   |  | <b>16. SOCIAL SECURITY NO.</b><br><u>218-01-8528</u>   |  |  | <b>17. INFORMANT</b><br><u>Mrs. Agnes M. Panzer</u> Address <u>(Same)</u>           |  |  |   |  |  |   |  |  |   |  |  |
| <b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Myocardial infarction or, lungs + liver</u><br>165X<br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____<br>INTERVAL BETWEEN ONSET AND DEATH _____   |  |  |   |   |  |  |  |  |   |  |  |   |  |  |   |  |  |   |  |  |
| <b>19. WAS AUTOPSY PERFORMED?</b><br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |  |   |   |  |  |  |  |   |  |  |   |  |  |   |  |  |   |  |  |
| <b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)<br><b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)<br><b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. p.m. <u>19</u><br><b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/><br><b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)<br><b>20f. (City or town) (County) (State)</b> |  |  |   |   |  |  |  |  |   |  |  |   |  |  |   |  |  |   |  |  |
| <b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>12-26</u> , 19 <u>67</u> , to <u>12-30</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>Dec. 30</u> , 19 <u>67</u> , and that death occurred at <u>2:50</u> PM, from the causes and on the date stated above.   |  |  |   |   |  |  |  |  |   |  |  |   |  |  |   |  |  |   |  |  |
| <b>22a. SIGNATURE</b><br><u>Anastacia Fabie</u>   |  |  |   |   |  | <b>22b. DATE SIGNED</b><br><u>12-30-67</u>   |  |  |   |  |  |   |  |  |   |  |  |   |  |  |
| <b>22c. PHYSICIAN'S NAME</b> (Type)<br><u>ANASTACIA FABIE</u>   |  |  |   |   |  | <b>22d. ADDRESS</b><br><u>GREATER BALT. Med. CENTER</u>  |  |  |   |  |  |   |  |  |   |  |  |   |  |  |
| <b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify)<br><u>Burial</u>   |  |  |   | <b>23b. DATE THEREOF</b><br><u>1/13/68.</u> |  | <b>23c. NAME OF CEMETERY OR CREMATORY</b><br><u>Parkwood Cemetery</u>  |  |  | <b>23d. LOCATION</b> (City, town or county) (State)<br><u>Baltimore, Md.</u>        |  |  |   |  |  |   |  |  |   |  |  |
| <b>24. FUNERAL DIRECTOR</b><br><u>Leonard J. Ruck, Inc. Balto. Md. 21214</u>  |  |  |   |   |  | <b>25a. REC'D BY REGISTRAR</b><br><u>JAN 2 1968</u>  |  |  |   |  |  |   |  |  |   |  |  |   |  |  |
| <b>25b. REGISTRAR'S SIGNATURE</b><br><u>[Signature]</u>   |  |  |   |   |  |  |  |  |   |  |  |   |  |  |   |  |  |   |  |  |





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
Item 4 Film 3395 1/2/68 KK  
16632  
10625  
10625  
10625

|   |                                  |   |   |  |  |   |   |
|---|----------------------------------|---|---|--|--|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Baltimore</u> MARYLAND  |                                  |   |   | 2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission)<br>a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> |  |   |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Towson</u>   |                                  | c. LENGTH OF STAY IN lb   |   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Towson</u>  |  | d. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><u>35 McLehary Avenue</u>   |                                  |   |   | d. STREET ADDRESS<br><u>35 McLehary Avenue</u>   |  |   |   |
| 3. NAME OF DECEASED (Type or print)<br><u>Joseph Stieber Parker</u>   |                                  |   |   | 4. DATE OF DEATH<br>Month <u>December</u> Day <u>23</u> Year <u>1967</u>   |  |   |   |
| 5. SEX<br><u>Male</u>   | 6. COLOR OR RACE<br><u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><u>March 17, 1884</u> | 9. AGE (in years last birthday) yrs<br><u>83</u>   | 10. UNDER 1 YEAR<br>Months <u>03</u> Days <u>1</u> Hours <u>00</u> Min <u>00</u> |   |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Store Junior Operator</u>   |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>Retail Grocer</u>   |   | 11. BIRTHPLACE (County & State, or foreign country)<br><u>Maryland</u>   |  | 12. CITIZEN OF WHAT COUNTRY?<br><u>USA</u>  |   |
| 13. FATHER'S NAME<br><u>Richard Parker</u>  |                                  |   |   | 14. MOTHER'S MAIDEN NAME<br><u>Catherine Stieber</u>   |  |   |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><u>No</u>  |                                  | 16. SOCIAL SECURITY NO<br><u>None</u>   |   | 17. INFORMANT<br><u>Family Records</u>   |  |   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY:<br><u>332X</u> IMMEDIATE CAUSE (a) <u>Cerebral Infarction</u><br>DUE TO <u>Long Middle Cerebral Artery Occlusion</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:<br>(b) <u>Arteriosclerosis</u><br>(c) <u>Arteriosclerosis</u> |                                  |   |   |  |  |   | INTERVAL BETWEEN ONSET AND DEATH<br><u>5 days</u>   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)  |                                  |   |   |  |  |   | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                                  | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)  |   |  |  |   |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour <u>19</u> a.m. p.m.  |                                  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>   |   | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |  | 20f. (City or town) (County) (State)  |   |
| 21. I certify that (I) (this hospital) attended the deceased from <u>12-22</u> , 19 <u>67</u> , to <u>12-22</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>12-22</u> , 19 <u>67</u> , and that death occurred at <u>7:44</u> A.M., from causes and on the date stated above.  |                                  |   |   |  |  |   |   |
| 22a. SIGNATURE<br><u>Kyle G. Swisher Jr</u>   |                                  |   |   | M.O. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>       |  | 22b. DATE SIGNED<br><u>12-26-67</u>   |   |
| 22c. PHYSICIAN'S NAME (Type)<br><u>Kyle G. Swisher Jr</u>   |                                  |   |   | 22d. ADDRESS<br><u>U.N.V. Hsp - Balld, Md</u>  |  |   |   |
| 23a. BURIAL, CREMAT OR REMOVAL (Specify)<br><u>Burial</u>   |                                  | 23b. DATE THEREOF<br><u>Dec. 26, 1967</u>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Prospect Hill Cemetery</u>  |  | 23d. LOCATION (City or Town) (County) (State)<br><u>Towson, Maryland</u>                          |   |
| 24. FUNERAL DIRECTOR<br><u>John Burns' Sons, Towson, Maryland</u>   |                                  |   |   | 25a. REC'D BY REGISTRAR<br>OATH <u>DEC 28 1967</u>   |  | 25b. REGISTRAR'S SIGNATURE<br><u>Charles Judge</u>  |   |



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

16630

16626

|   |   |   |  |
|---|---|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Baltimore</b> MARYLAND  |   | 2. USUAL RESIDENCE (Where deceased lived, if institut on: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Harford</b> ✓                |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Catonsville</b>  |   | c. LENGTH OF STAY IN 1b<br><b>4 yrs 4 mo</b>  |  |
| c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Bel Air Md.</b>  |   | 1 2   |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>Spring Grove State Hospital</b>  |   | d. STREET ADDRESS<br><b>141 Fairmont Drive</b>  |  |
| e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |   |   |  |
| 3. NAME OF DECEASED (Type or print)<br>First Middle Last<br><b>Catherine Estelle Parr</b>   |   | 4. DATE OF DEATH<br>Month Day Year<br><b>12 15 19 67</b>  |  |
| 5. SEX<br><b>female</b>   | 6. COLOR OR RACE<br><b>white</b>  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>12 2 1895</b>                                 |
| 9. AGE (In years last birthday)<br><b>72 yrs.</b>   |   | IF UNDER 1 YEAR<br>Months Days Hours Min.<br><b>12 15 19 67</b>   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)   |   | 10b. KIND OF BUSINESS OR INDUSTRY   |  |
| 11. BIRTHPLACE (County & State, or foreign country)<br><b>New York</b>  |   | 12. CITIZEN OF WHAT COUNTRY?<br><b>U S</b>  |  |
| 13. FATHER'S NAME<br><b>Unknown</b>   |   | 14. MOTHER'S MAIDEN NAME<br><b>Unknown</b>  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)   |   | 16. SOCIAL SECURITY NO.   |  |
| 17. INFORMANT<br><b>Hospital records</b>  |   | Address   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY.<br>IMMEDIATE CAUSE (a) <b>CARDIAC FAILURE</b> days<br>DUE TO (b) <b>Generalized arteriosclerosis</b> years<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(c) |   |   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |   |   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m.<br><b>19</b>   | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/><br>of work of work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  | 20f. (City or town) (County) (State)                                 |
| 21. I certify that (I) (this hospital) attended the deceased from <b>19</b> to <b>Dec 15, 19 67</b> , that (I) (we) last saw the deceased alive on <b>Dec 15, 19 67</b> , and that death occurred at <b>Trip</b> , from causes and on the date stated above.  |   |   |  |
| 22a. SIGNATURE<br><b>George Rodon</b>   |   | 22b. DATE SIGNED<br><b>12-16-67</b>   |  |
| 22c. PHYSICIAN'S NAME (Type)<br><b>George A. Rodon M.D.</b>   |   | 22d. ADDRESS<br><b>Spring Grove St. Hosp.</b>   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>  | 23b. DATE THEREOF<br><b>12/20/67</b>  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>EAST LAWN</b>  | 23d. LOCATION (City or Town) (County) (State)<br><b>ITHACA, N.Y.</b> |
| 24. FUNERAL DIRECTOR<br><b>E.S. MALNABE 301 FREDERICK RD 21228</b>  |   | 25a. REC'D BY REGISTRAR<br><b>DEC 18 1967</b>   |  |
| 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>  |   |   |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

16634

16627

|   |                                  |  |  |  |   |   |   |
|---|----------------------------------|--|--|--|---|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Baltimore</b> MARYLAND  |                                  |  |  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> |   |   |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Garrison</b>   |                                  | c. LENGTH OF STAY IN 1b<br><b>1 week</b>   |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Reisterstown</b>                                      |   |   |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>Foxleigh Nursing Home</b>  |                                  |  |  | d. STREET ADDRESS<br><b>203 Greenview Ave.</b>   |   |   |   |
| 3. NAME OF DECEASED<br>(Type or print)<br><b>Francis Xavier Patrick</b>   |                                  |  |  | 4. DATE OF DEATH<br>Month <b>December</b> Day <b>24</b> Year <b>1967</b>   |   |   |   |
| 5. SEX<br><b>Male</b>   | 6. COLOR OR RACE<br><b>White</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>    | 8. DATE OF BIRTH<br><b>May 4, 1900</b> | 9. AGE (In years last birthday)<br><b>67</b> yrs   | 10. UNDER 1 YEAR<br>Months <b>12</b> Days <b>19</b> Hours <b>67</b> Min |   | 11. UNDER 24 HRS<br>Hours <b>67</b> Min |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Ass. Office Manager Stock Broker</b>  |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Stock Broker</b>   |  | 11. BIRTHPLACE (County & State, or foreign country)<br><b>Baltimore, Maryland</b>  |   | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |   |
| 13. FATHER'S NAME<br><b>Joseph Patrick</b>  |                                  |  |  | 14. MOTHER'S MAIDEN NAME<br><b>Isabelle Magness</b>  |   |   |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) <b>No</b>  |                                  | 16. SOCIAL SECURITY NO<br><b>212-09-4260</b>   |  | 17. INFORMANT<br>Address <b>203 Greenview Av</b><br><b>Catherine Patrick Reisterstown, Md</b>  |   |   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <b>Cerebral Vascular Accident</b><br>DUE TO (b) <b>Arteriosclerosis - generalized</b><br>DUE TO (c) <b>Emphysema</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |                                  |  |  |  |   | INTERVAL BETWEEN ONSET AND DEATH<br><b>4 days</b><br><b>9 years</b><br><b>9 years</b>             |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |                                  |  |  |  |   | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |  |   |   |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. <b>19</b> p.m.  |                                  | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Not While <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/> |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |   | 20f. (City or town) (County) (State)  |   |
| 21. I certify that (I) (this hospital) attended the deceased from <b>July</b> , 1967, to <b>December 24</b> , 1967, that (I) (we) last saw the deceased alive on <b>December 24</b> , 1967, and that death occurred at <b>11:00 PM</b> , from causes and on the date stated above.  |                                  |  |  |  |   |   |   |
| 22a. SIGNATURE<br><b>Clarence E. McWilliams</b>   |                                  |  |  | 22b. DATE SIGNED<br><b>12-25-67</b>  |   | 22c. PHYSICIAN'S NAME (Type)<br><b>Clarence E. McWilliams</b>                                     |   |
| 22d. ADDRESS<br><b>11904 Greenview Ave Reisterstown, Md</b>   |                                  |  |  | 22e. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>   |   |   |   |
| 23a. BURIAL (CREMATION, REMOVAL) (Specify)<br><b>Burial</b>   |                                  | 23b. DATE THEREOF<br><b>Dec. 28, 1967</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Evergreen Mem. Gardens</b>  |   | 23d. LOCATION (City or town) (County) (State)<br><b>Finksburg, Maryland</b>                       |   |
| 24. FUNERAL DIRECTOR<br><b>H. J. Eckhardt</b>   |                                  | ADDRESS<br><b>Owings Mills, Maryland</b>   |  | 25a. REC'D BY REGISTRAR<br><b>DEC 28 1967</b>  |   | 25b. REGISTRAR'S SIGNATURE<br><b>Clarence E. McWilliams</b>                                       |   |



## CERTIFICATE OF DEATH

16628

16635

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

|   |                              |   |   |
|---|------------------------------|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>BALTIMORE</b> MARYLAND  |                              | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <b>MARYLAND</b> b. COUNTY <b>BALTIMORE</b>                |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>BALTIMORE</b>  |                              | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>BALTIMORE</b> P.O. 21212   |   |
| c. LENGTH OF STAY IN 1b<br><b>16 MO.</b>  |                              | d. STREET ADDRESS<br><b>7117 YORK ROAD</b>  |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>ARMADOST NURSING HOME 812 REGESTER AVE - BALTO 21212</b>   |                              | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   |
| 3. NAME OF DECEASED (Type or print)<br>First <b>EMMA</b> Middle <b>BEATRICE</b> Last <b>PATTEN</b>  |                              | 4. DATE OF DEATH<br>Month <b>12</b> Day <b>9</b> Year <b>1967</b>   |   |
| 5. SEX<br><b>F</b>  | 6. COLOR OR RACE<br><b>W</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>AUG-20, 1879</b> |
| 9. AGE (In years last birthday)<br><b>83 yrs</b>  |                              | 10. IF UNDER 1 YEAR<br>Months <b>9</b> Days <b>9</b> Hours <b>19</b> Min <b>67</b>  |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>HOUSE WIFE</b>  |                              | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>HOME</b>  |   |
| 11. BIRTHPLACE (County & State, or foreign country)<br><b>RISING SUN, MD</b>  |                              | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |   |
| 13. FATHER'S NAME<br><b>JOHN KEILHOLTZ</b>  |                              | 14. MOTHER'S MAIDEN NAME<br><b>MARTHA EMMA KIRK</b>   |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><b>NO</b>  |                              | 16. SOCIAL SECURITY NO<br><b>218-54-2853</b>  |   |
| 17. INFORMANT<br><b>EARL ERSON K PATTEN</b>   |                              | Address <b>7117 YORK RD. BALTIMORE, MD</b>  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Acute Cardiac Failure</b><br>DUE TO <b>Atherosclerosis</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) <b>1 yr</b><br>(c) |                              |   | INTERVAL BETWEEN ONSET AND DEATH        |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |                              |   |   |
| 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |                              |   |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)  |                              | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)   |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. <b>19</b> p.m.  |                              | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>  |   |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |                              | 20f. (City or town) (County) (State)  |   |
| 21. I certify that (I) (this hospital) attended the deceased from <b>July 10, 1960</b> , to <b>Dec 9, 1967</b> , that (I) (we) last saw the deceased alive on <b>Dec 9, 1967</b> , and that death occurred at <b>5 A.M.</b> from causes and on the date stated above.   |                              |   |   |
| 22a. SIGNATURE<br><b>Lawrence C. Post</b>   |                              | 22b. DATE SIGNED<br><b>12/11/67</b>   |   |
| 22c. PHYSICIAN'S NAME (Type)<br><b>LAWRENCE C. POST</b>   |                              | 22d. ADDRESS<br><b>6705 York Rd - Baltimore 21220</b>   |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>  |                              | 23b. DATE THEREOF<br><b>12/12/67</b>  |   |
| 23c. NAME OF CEMETERY OR CREMATORY<br><b>WESTNOTTINGHAM CEM.</b>  |                              | 23d. LOCATION (City or Town) (County) (State)<br><b>COLORA CELIL MD</b>   |   |
| 24. FUNERAL DIRECTOR<br><b>RALPH M. REED</b><br><b>Ralph M Reed</b>   |                              | 25a. REC'D BY REGISTRAR<br><b>DEC 11 1967</b>   |   |
| ADDRESS<br><b>RISING SUN, MD</b>  |                              | 25b. REGISTRAR'S SIGNATURE<br><b>J Charles Judge</b>  |   |





TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20 M 1/66

16636

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

# CERTIFICATE OF DEATH

16621

|   |                                  |   |                                    |
|---|----------------------------------|---|------------------------------------|
| 1 PLACE OF DEATH<br>a. COUNTY <b>Baltimore</b> MARYLAND   |                                  | 2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Harford</b>                    |                                    |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)  |                                  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)  |                                    |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>St. Joseph Hospital, Towson, Md.</b>   |                                  | d. STREET ADDRESS <b>706 Pulaski Highway</b><br><del>503 Adams Road</del>   |                                    |
| 3 NAME OF DECEASED (Type or print)<br>First Middle Last<br><b>TRINA Baby MARIE Girl PAYTON</b>  |                                  | 4. DATE OF DEATH<br>Month Day Year<br><b>December 8 19 67</b>   |                                    |
| 5 SEX<br><b>Female</b>  | 6. COLOR OR RACE<br><b>white</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>12-5-67</b> |
| 9 AGE (In years lost birthday) yrs  |                                  | 10. IF UNDER 1 YEAR<br>Months Days Hours Min.   |                                    |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>none</b>  |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>none</b>  |                                    |
| 11 BIRTHPLACE (County & State, or foreign country)<br><b>Baltimore Co., Md.</b>   |                                  | 12 CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |                                    |
| 13. FATHER'S NAME<br><b>Johnnie Payton</b>  |                                  | 14. MOTHER'S MAIDEN NAME<br><b>Reba Wooten</b>  |                                    |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><b>no</b>  |                                  | 16. SOCIAL SECURITY NO<br><b>none</b>   |                                    |
| 17. INFORMANT<br><b>Mrs. Reba Payton, 706 Pulaski Highway, Joppa</b>  |                                  | Address d.  |                                    |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Prematurity</b><br>776X<br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b)<br>(c)        |                                  | INTERVAL BETWEEN ONSET AND DEATH  |                                    |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)  |                                  |   |                                    |
| 19. WAS AUTOPSY PERFORMED?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |                                  |   |                                    |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)  |                                  | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)   |                                    |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m. <b>19</b>  |                                  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>   |                                    |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |                                  | 20f. (City or town) (County) (State)  |                                    |
| 21. I certify that <del>he</del> (this hospital) attended the deceased from <b>12-5-67</b> , 19 <b>12-8</b> , 1967, that <del>he</del> (we) last saw the deceased alive on <b>12-8</b> 19 <b>67</b> , and that death occurred at <b>8:15 PM</b> , from causes and on the date stated above. |                                  |   |                                    |
| 22a. SIGNATURE<br><b>R. Orjuela-Gomez, M.D.</b>   |                                  | 22b. DATE SIGNED<br><b>12-9-67</b>  |                                    |
| 22c. PHYSICIAN'S NAME (Type)<br><b>R. Orjuela-Gomez, M.D.</b>   |                                  | 22d. ADDRESS<br><b>7620 York Road, Towson, Md. 21204</b>  |                                    |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>burial</b>  |                                  | 23b. DATE THEREOF<br><b>Dec. 11, 1967</b>   |                                    |
| 23c. NAME OF CEMETERY OR CREMATORY<br><b>Harford Memorial Gardens</b>   |                                  | 23d. LOCATION (City or Town) (County) (State)<br><b>Aberdeen Harford Md</b>   |                                    |
| 24. FUNERAL DIRECTOR<br><b>Howard M. Thomas, Son, Abington, Md. 21002</b>   |                                  | 25a. REC'D BY REGISTRAR<br><b>DEC 13 1967</b>   |                                    |
| 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>  |                                  |   |                                    |



## CERTIFICATE OF DEATH

1663

1663

|   |                                  |  |                                     |   |   |  |  |
|---|----------------------------------|--|-------------------------------------|---|---|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Baltimore</b> MARYLAND  |                                  |  |                                     | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)<br>a. STATE <b>Md.</b> 21213 b. COUNTY <b>Baltimore</b> |   |  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Idlewild</b>   |                                  | c. LENGTH OF STAY in 1b  |                                     | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Baltimore</b>  |   |  |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>Armcast Nursing Home</b>   |                                  |  |                                     | d. STREET ADDRESS<br><b>2221 Lake Ave.</b>  |   | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>FRANCES</b> Middle <b>A.</b> Last <b>PETERKA</b>  |                                  |  |                                     | 4. DATE OF DEATH<br>Month <b>Dec.</b> Day <b>25</b> Year <b>1967</b>  |   |  |  |
| 5. SEX<br><b>female</b>   | 6. COLOR OR RACE<br><b>white</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>3/8/1888</b> |   | 9. AGE (In years last birthday)<br><b>79</b> yrs. | 10. IF UNDER 1 YEAR<br>Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min <input type="checkbox"/> |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>housewife</b>   |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>at home</b>  |                                     | 11. BIRTHPLACE (County & State, or foreign country)<br><b>Czechoslovakia</b>  |   | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  |
| 13. FATHER'S NAME<br><b>Joseph Slechta</b>  |                                  |  |                                     | 14. MOTHER'S MAIDEN NAME<br><b>unknown</b>  |   |  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)   |                                  | 16. SOCIAL SECURITY NO.  |                                     | 17. INFORMANT<br><b>Marie J. Peterka, dght. above</b> Address   |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Carcinoma of Pancreas</b><br>15 17<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. }<br>DUE TO (b)<br>DUE TO (c) |                                  |  |                                     |   |   | INTERVAL BETWEEN ONSET AND DEATH<br><b>10 months</b>   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)   |                                  |  |                                     |   |   | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |                                     |   |   |  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. <b>19</b> p.m.  |                                  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>  |                                     | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |   | 20f. (City or town) (County) (State)   |  |
| 21. I certify that (I) (this hospital) attended the deceased from <b>Nov. 22, 1967</b> to <b>Dec. 25, 1967</b> , that (I) (we) last saw the deceased alive on <b>Dec. 24, 1967</b> , and that death occurred at <b>2:30 AM</b> , from causes and on the date stated above                             |                                  |  |                                     |   |   |  |  |
| 22a. SIGNATURE<br><b>Dr. Loy Zimmerman</b>  |                                  |  |                                     | 22b. DATE SIGNED<br><b>12/27/67</b>   |   | 22c. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>   |  |
| 22d. ADDRESS<br><b>3202 Harford Road</b>  |                                  |  |                                     |   |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |                                  | 23b. DATE THEREOF<br><b>12/28/67</b>   |                                     | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Holy Redeemer Cem.</b>   |   | 23d. LOCATION (City or Town) (County) (State)<br><b>Baltimore, Md.</b>   |  |
| 24. FUNERAL DIRECTOR<br><b>Schumacher Funeral Home, Inc.</b><br><b>3331 Brehms Lane</b>   |                                  |  |                                     | 25a. REC'D BY REGISTRAR<br><b>DATE DEC 28 1967</b>  |   | 25b. REGISTRAR'S SIGNATURE   |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## CERTIFICATE OF DEATH

16633

16634

|  |  |   |  |
|--|--|---|--|
| 1 PLACE OF DEATH<br>a. COUNTY <b>Baltimore</b><br>MARYLAND   |  | 2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission)<br>a. STATE <b>Maryland</b><br>b. COUNTY <b>Prince George's</b>        |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Catonsville</b>   |  | c. LENGTH OF STAY IN 1b<br><b>4yr9mth3dys</b>   |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>SPRING GROVE STATE HOSPITAL</b>   |  | e. STREET ADDRESS<br><b>6106 Arbor Street</b>   |  |
| 3. NAME OF DECEASED<br>(Type or print)<br><b>William Charles Petrie, Sr.</b>   |  | 4. DATE OF DEATH<br>Month <b>December</b> Day <b>12</b> Year <b>67</b>  |  |
| 5. SEX<br><b>male</b>  | 6. COLOR OR RACE<br><b>white</b>   | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>July 1, 1888</b>  |
| 9. AGE (In years last birthday)<br><b>79</b> yrs   |  | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>plasterer</b>  |  |
| 11. BIRTHPLACE (County & State, or foreign country)<br><b>Scotland</b>   |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U. S.</b>  |  |
| 13. FATHER'S NAME<br><b>William Petrie</b>   |  | 14. MOTHER'S MAIDEN NAME<br><b>Mary McGovern</b>  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) (If yes give war or dates of service)<br><b>Army WWI C 209 649</b>  |  | 16. SOCIAL SECURITY NO<br><b>219-07-3474</b>  |  |
| 17. INFORMANT<br><b>Records: SPRING GROVE STATE HOSPITAL</b>   |  | Address   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Bronchopneumonia, right lower lobe, organism</b><br>DUE TO <b>unknown</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:<br>(b) <b>Malnutrition and dehydration</b><br>DUE TO <b>with cerebral arteriosclerosis</b><br>(c) <b>Anorexia and Chronic Brain Syndrome also</b> |  |   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Arteriosclerotic Cardiovascular Ht. Dis.; Decubitus Ulcer,</b>  |  |   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. <b>19</b><br>p.m.  | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Not While <input type="checkbox"/><br>at work at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  | 20f. (City or town) (County) (State)   |
| 21. I certify that <b>he</b> (this hospital) attended the deceased from <b>March 8, 1963</b> to <b>Dec. 12, 1967</b> , that <b>he</b> (we) last saw the deceased alive on <b>Dec. 12, 1967</b> , and that death occurred at <b>10:55</b> M, from causes and on the date stated above.  |  |   |  |
| 22a. SIGNATURE<br><i>Anthony J. Young</i>  |  | 22b. DATE SIGNED<br><b>12-13-67</b>   |  |
| 22c. PHYSICIAN'S NAME (Type)<br><b>Anthony J. Young, M.D.</b>  |  | 22d. ADDRESS<br><b>SPRING GROVE STATE HOSPITAL<br/>Catonsville, Maryland 21228</b>  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   | 23b. DATE THEREOF<br><b>12-16-67</b>   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>FORT LINCOLN</b>   | 23d. LOCATION (City or Town) (County) (State)<br><b>COLMAR MANOR, MARYLAND</b> |
| 24. FUNERAL DIRECTOR<br><b>W.W. Chamber is</b>   |  | 25a. REC'D BY REGISTRAR<br><b>DEC 18 1967</b>   |  |
| 25b. REGISTRAR'S SIGNATURE<br><i>Charles Judge</i>   |  |   |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 4 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

VR A15 (4)  
25M 1/67

1663

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1663

|   |   |   |   |
|---|---|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Baltimore</b><br>MARYLAND   |   | 2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>                 |   |
| b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town)<br><b>Catonsville</b>   |   | c. LENGTH OF STAY IN 1b<br><b>30-4</b>  |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>Shady Nook Nursing Home</b>  |   | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |   |
| 3. NAME OF DECEASED (Type or print)<br><b>Lucy V. Phebus</b>  |   | 4. DATE OF DEATH<br>Month <b>December</b> Day <b>9</b> Year <b>1967</b>   |   |
| 5. SEX<br><b>Female</b>   | 6. COLOR OR RACE<br><b>White</b>  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>1-12-1890</b>  |
| 9. AGE (In years last birthday) yrs.<br><b>77</b>   |   | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housewife</b>  | 11. BIRTHPLACE (County & State or foreign country)<br><b>Maryland</b>                             |
| 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |   | 13. FATHER'S NAME<br><b>Fuller Wright</b>   |   |
| 14. MOTHER'S MAIDEN NAME<br><b>Mary Warfield</b>  |   | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)   |   |
| 16. SOCIAL SECURITY NO  |   | 17. INFORMANT<br>Address<br><b>Mrs. Lois Frey, 132 S. Collins Ave. 21229</b>  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>ATHEROSCLEROTIC CV HEART DISEASE</b><br>7-7-7-1<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b)<br>(c)<br>INTERVAL BETWEEN ONSET AND DEATH<br><b>2 WKS.</b> |   |   |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br><b>DIABETES MELLITUS. BILATERAL LEG AMPUTATIONS.</b>   |   |   | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |   | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)  |   |
| 20c. TIME OF INJURY Month Day, Year<br>Hour a.m. p.m. <b>19</b>   | 20d. INJURY OCCURRED<br>While of work <input type="checkbox"/> Not While of work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  | 20f. (City or town) (County) (State)  |
| 21. I certify that (I) (this hospital) attended the deceased from <b>12/5/67</b> , 19 <b>67</b> to <b>12-9</b> , 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>12-9</b> , 19 <b>67</b> , and that death occurred at <b>4:40 PM</b> , from causes and on the date stated above  |   |   |   |
| 22a. SIGNATURE<br><b>Dr. John F. Schaefer</b>   |   | 22b. DATE SIGNED<br><b>12/11/67</b>   |   |
| 22c. PHYSICIAN'S NAME (Type)<br><b>Dr. John F. Schaefer</b>   |   | 22d. ADDRESS<br><b>401 Random Road, Balto. Md.</b>  |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>  | 23b. DATE THEREOF<br><b>12-13-1967</b>  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Jennings Chapel</b>  | 23d. LOCATION (City or Town) (County) (State)<br><b>Florence, Maryland</b>                        |
| 24. FUNERAL DIRECTOR<br><b>Howard H. Hubbard, 4107 Wilkens Avenue 21229</b>   |   | 25a. REC'D BY REGISTRAR<br><b>DEC 12 1967</b>   |   |
| 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>  |   |   |   |

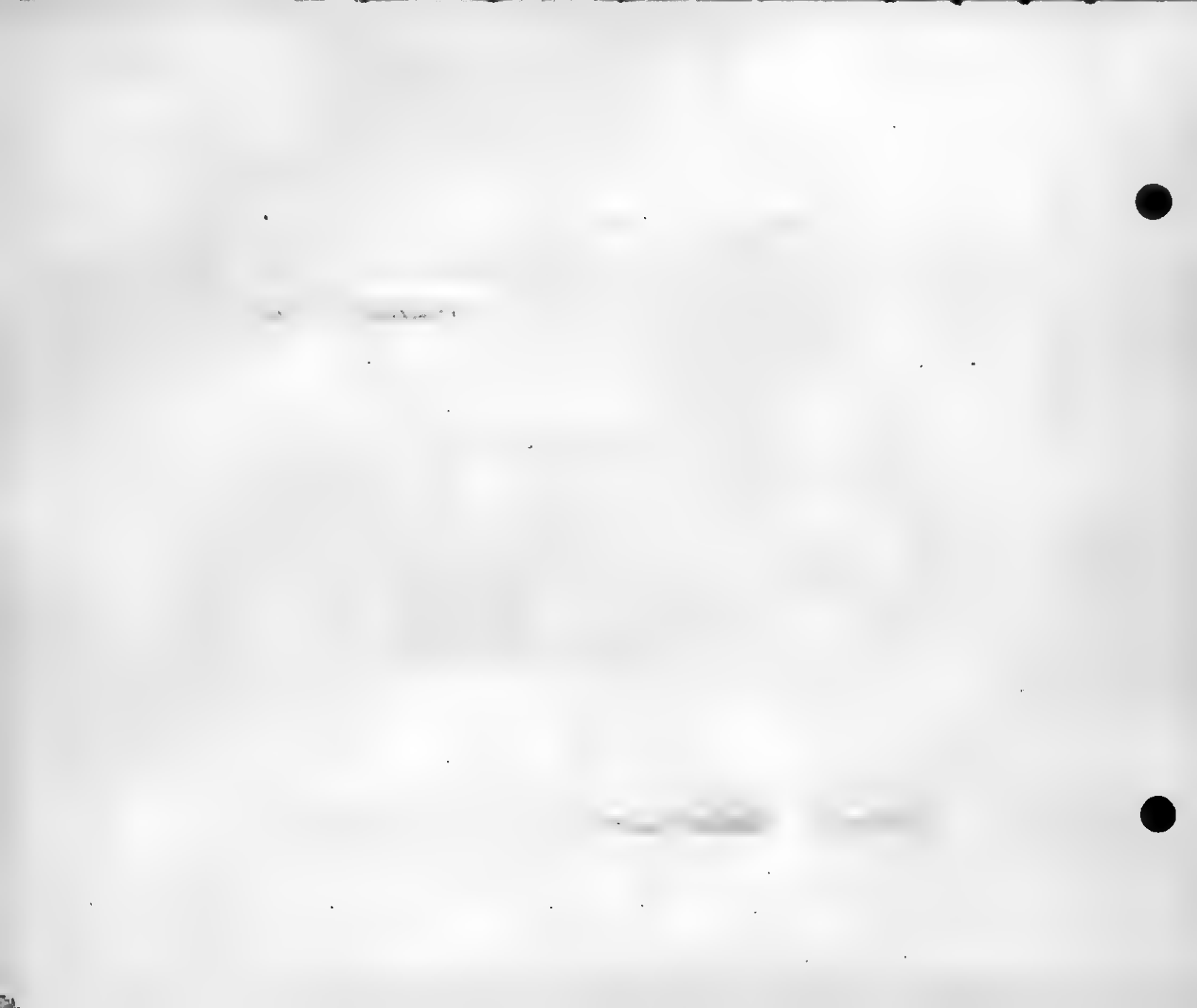




TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

| DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  |  |                                      |   |   |   |                                     |   |   |  |  |  |
|---|--|--------------------------------------|---|---|---|-------------------------------------|---|---|--|--|--|
| CERTIFICATE OF DEATH  |  |                                      |   |   |   |                                     |   |   |  |  |  |
| 1. PLACE OF DEATH<br>a. COUNTY <b>Baltimore</b> MARYLAND  |  |                                      |   |   | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>b. STATE <b>MD</b> d. COUNTY                                   |                                     |   |   |  |  |  |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)<br><b>Rural - Towson</b>   |  |                                      | c. LENGTH OF STAY IN 1b<br><b>17 days</b>   |   | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)<br><b>BALTIMORE 21224</b>  |                                     |   |   |  |  |  |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)<br><b>Greater Baltimore Medical Center</b>   |  |                                      |   |   | d. STREET ADDRESS<br><b>10 S. HIGHLAND AVE</b>  |                                     |   | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |
| 3. NAME OF DECEASED (Type or print)<br>First Middle Last<br><b>Peter Paul Pietrowicz</b>  |  |                                      | 4. DATE OF DEATH<br>Month Day Year<br><b>12 10 1967</b>   |   |   |                                     |   |   |  |  |  |
| 5. SEX<br><b>Male</b>   |  | 6. COLOR OR RACE<br><b>Cau</b>       |   | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 8. DATE OF BIRTH<br><b>11-22-96</b> |   | 9. AGE (In years last birthday) <b>71</b> yrs.  |  |  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>LONG-DURATION</b>   |  |                                      | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>SHIPS</b>   |   | 11. BIRTHPLACE (County & State, or foreign country)<br><b>PENNSYLVANIA</b>  |                                     |   | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A</b>  |  |  |  |
| 13. FATHER'S NAME<br><b>STANISLAW PIETROWICZ</b>  |  |                                      |   |   | 14. MOTHER'S MAIDEN NAME<br><b>JOSEPHINE</b>  |                                     |   |   |  |  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><b>YES</b>   |  |                                      | 16. SOCIAL SECURITY NO.<br><b>216-09-4683</b>   |   | 17. INFORMANT<br><b>ROSE PIETROWICZ</b> Address <b>21224</b>  |                                     |   |   |  |  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Carotid Artery hemorrhage</b><br><b>171</b><br>Conditions, if any, which gave rise to Immediate cause (a), stating the underlying cause last. }<br>DUE TO (b) <b>Carcinoma of base of tongue</b><br>DUE TO (c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) |  |                                      |   |   |   |                                     |   | INTERVAL BETWEEN ONSET AND DEATH  |  |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |                                      |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)  |   |                                     |   |   |  |  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m.<br><b>19</b>   |  |                                      | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> |   | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |                                     | 20f. (City or town) (County) (State)                                  |   |  |  |  |
| 21. I certify that (I) (this hospital) attended the deceased from <b>11/24</b> , 19 <b>67</b> , to <b>12/10</b> , 1967, that (I) (we) last saw the deceased alive on <b>12/10</b> 19 <b>67</b> , and that death occurred at <b>9:00 PM</b> from the causes and on the date stated above.  |  |                                      |   |   |   |                                     |   |   |  |  |  |
| 22a. SIGNATURE<br><b>John E. Adams</b>  |  |                                      |   |   | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/><br>M.O. <b>12/11/67</b> |                                     |   | 22b. DATE SIGNED  |  |  |  |
| 22c. PHYSICIAN'S NAME (Type)<br><b>John E. Adams, M.D.</b>  |  |                                      |   |   | 22d. ADDRESS<br><b>6701 N. Charles Street</b>   |                                     |   |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |  | 23b. DATE THEREOF<br><b>12-14-67</b> |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>HOLY ROSARY Cem.</b>   |   |                                     | 23d. LOCATION (City, town or county) (State)<br><b>BALTO. Co. MD.</b> |   |  |  |  |
| 24. FUNERAL DIRECTOR<br><b>U. FIALKOWSKI 2007 EASTERN AVE.</b>  |  |                                      |   |   | 25a. REC'D BY REGISTRAR<br><b>DEC 13 1967</b>   |                                     |   |   |  | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b> |  |
| <b>U. Fialkowski BALTO MD 21231</b>   |  |                                      |   |   |   |                                     |   |   |  |  |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH   |  |  |   |   |  |   |  |   |   |  |  |  |  |  |  |  |  |
|---|--|--|---|---|--|---|--|---|---|--|--|--|--|--|--|--|--|
| DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  |  |  |   |   |  |   |  |   |   |  |  |  |  |  |  |  |  |
| 16641 CERTIFICATE OF DEATH 16634  |  |  |   |   |  |   |  |   |   |  |  |  |  |  |  |  |  |
| 1. PLACE OF DEATH<br>a. COUNTY <b>Baltimore</b><br>b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Towson</b><br>c. LENGTH OF STAY IN 1b<br><b>MARYLAND</b><br>d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>7814 Ruxway Road</b>   |  |  |   |   |  | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)<br>a. STATE <b>Maryland</b><br>b. COUNTY <b>Baltimore</b><br>c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b><br>d. STREET ADDRESS <b>3009 Arunah Avenue</b><br>e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |   |   |  |  |  |  |  |  |  |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Sylvia</b> Middle <b>Louise</b> Last <b>Pollard</b>   |  |  | 4. DATE OF DEATH<br>Month <b>12</b> Day <b>5</b> Year <b>19 67</b>  |   |  | 5. SEX <b>Female</b>  |  |   | 6. COLOR OR RACE <b>Negro</b>   |  |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  |  |  |  |
| 8. DATE OF BIRTH <b>Sept. 14, 1916</b>  |  |  | 9. AGE (In years last birthday) <b>51</b> yrs.  |   |  | 10. IF UNDER 1 YEAR Months <b>1</b> Days <b>1</b>   |  |   | 11. IF UNDER 24 HRS. Hours <b>1</b> Mins. <b>0</b>                    |  |  |  |  |  |  |  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Domestic</b>   |  |  |   | 10b. KIND OF BUSINESS OR INDUSTRY <b>Private Family</b> |  |   |  | 11. BIRTHPLACE (City & State, or foreign country) <b>Gloucester CO. VA.</b> |   |  |  | 12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>   |  |  |  |  |  |
| 13. FATHER'S NAME <b>Walker Pollard</b>   |  |  |   |   |  | 14. MOTHER'S MAIDEN NAME <b>Daisy Jones</b>   |  |   |   |  |  |  |  |  |  |  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>   |  |  |   |   |  | 16. SOCIAL SECURITY NO. <b>228-42-6047</b>  |  |   |   |  |  | 17. INFORMANT Address <b>Mr Robert Pollard 3009 Arunah Ave.</b>  |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <b>Hypertensive cardio vascular disease.</b><br>DUE TO (b)<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br>19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |   |   |  |   |  |   |   |  |  |  |  |  |  |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  |   |   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |   |   |  |  |  |  |  |  |  |  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a.m. <b>19</b><br>p.m. <b>19</b>  |  |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> |   |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |  |   | 20f. (City or town) (County) (State)                                  |  |  |  |  |  |  |  |  |
| 21. I certify that (I) (this hospital) attended the deceased from <b>1965</b> to <b>Nov 29, 1967</b> , that (I) (we) last saw the deceased alive on <b>Nov 29, 1967</b> , and that death occurred at <b>11</b> M, from the causes and on the date stated above.   |  |  |   |   |  |   |  |   |   |  |  |  |  |  |  |  |  |
| 22a. SIGNATURE <b>Green</b> M.D.  |  |  |   |   |  | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> <b>12/7/67</b>  |  |   | 22b. DATE SIGNED  |  |  |  |  |  |  |  |  |
| 22c. PHYSICIAN'S NAME (Type) <b>TORROT JUDY, MD</b>   |  |  |   |   |  | 22d. ADDRESS <b>549 N. Fulton Ave</b>   |  |   |   |  |  |  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>   |  |  | 23b. DATE THEREOF <b>12/9/67</b>  |   |  | 23c. NAME OF CEMETERY OR CREMATORY <b>Mount Calvary Cemetery</b>  |  |   | 23d. LOCATION (City, town or county) (State) <b>Baltimore CO. MD.</b> |  |  |  |  |  |  |  |  |
| 24. FUNERAL DIRECTOR'S SIGNATURE <b>Herbert E. Kutter</b> ADDRESS <b>3035 W. North Ave</b>  |  |  |   |   |  | 25a. REC'D BY REGISTRAR <b>DEC 12 1967</b>  |  |   | 25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>                       |  |  |  |  |  |  |  |  |

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

| MARYLAND STATE DEPARTMENT OF HEALTH   |   |   |  |
|---|---|---|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |   |   |  |
| 16642   |   | CERTIFICATE OF DEATH  |  |
| 16625   |   |   |  |
| 1. PLACE OF DEATH<br>a. COUNTY <b>BALTIMORE</b> MARYLAND  |   | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <b>MARYLAND</b> b. COUNTY <b>BALTIMORE</b>                |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>FORT HOWARD</b>  |   | c. LENGTH OF STAY IN lb<br><b>103 DAYS</b>  |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>VETERANS ADMINISTRATION HOSPITAL</b>   |   | e. STREET ADDRESS<br><b>29 LINCOLN AVENUE</b>   |  |
| 3. NAME OF DECEASED (Type or print)<br><b>LAWRENCE</b>  |   | 4. DATE OF DEATH<br>Month <b>DECEMBER</b> Day <b>14</b> Year <b>1967</b>  |  |
| 5. SEX<br><b>MALE</b>   | 6. COLOR OR RACE<br><b>NEGRO</b>  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>5/18/21</b>                 |
| 9. AGE (In years last birthday) yrs.<br><b>46</b>   |   | 10. IF UNDER 1 YEAR Months Days Hours Min<br><b>14</b> <b>1967</b>  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>MILLWRIGHT</b>  |   | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>LUMBER</b>  |  |
| 11. BIRTHPLACE (County & State, or foreign country)<br><b>TILLER, ARKANSAS</b>  |   | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  |
| 13. FATHER'S NAME<br><b>JOHN POLLOCK</b>  |   | 14. MOTHER'S MAIDEN NAME<br><b>MARY WILLIS</b>  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><b>YES WWII</b>  |   | 16. SOCIAL SECURITY NO<br><b>218 07 63 63</b>   |  |
| 17. INFORMANT<br><b>CLINICAL RECORDS, VAH, FT. HOWARD, MD.</b>  |   | Address   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>TERMINAL BRAIN TUMOR</b><br>DUE TO (b)<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)<br>DUE TO (c)<br>INTERVAL BETWEEN ONSET AND DEATH <b>MONTHS</b> |   |   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |   | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. <b>19</b><br>p.m. <b>19</b>   | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  | 20f. (City or town) (County) (State)               |
| 21. I certify that <b>XX</b> (this hospital) attended the deceased from <b>SEPT 2</b> , 19 <b>67</b> , to <b>DEC 14</b> , 19 <b>67</b> , that <b>X</b> (we) last saw the deceased alive on <b>DEC 14</b> , 19 <b>67</b> , and that death occurred at <b>6:50 PM</b> , from causes and on the date stated above                                  |   |   |  |
| 22a. SIGNATURE<br><i>Sung Ill Shin</i> M.D.   |   | 22b. DATE SIGNED<br><b>12/14/67</b>   |  |
| 22c. PHYSICIAN'S NAME (Type)<br><b>SUNG ILL SHIN, M.D.</b>  |   | 22d. ADDRESS<br><b>VAH, FORT HOWARD, MARYLAND</b>   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>  | 23b. DATE THEREOF<br><b>12/19/67</b>  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>BALTIMORE NATIONAL CEMETERY BALTIMORE, MARYLAND</b>  | 23d. LOCATION (City or Town) (County) (State)      |
| 24. FUNERAL DIRECTOR<br><b>HERBERT NUTTER FUNERAL HOME BALTIMORE, MD.</b>   |   | 25a. REC'D BY REGISTRAR<br><b>DEC 20 1967</b>   | 25b. REGISTRAR'S SIGNATURE<br><i>Charles Judge</i> |



\*\*\*

1 1 1



..

1 1

## CERTIFICATE OF DEATH

16643

15636

|   |                                 |   |   |
|---|---------------------------------|---|---|
| 1 PLACE OF DEATH<br>a. COUNTY <b>BALTIMORE</b><br>MARYLAND  |                                 | 2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)<br>a. STATE <b>MARYLAND</b><br>b. COUNTY <b>BALTO</b>                     |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>REISTERSTOWN</b>   |                                 | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>REISTERSTOWN</b>   |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not a hospital, give street address)<br><b>MILFORD MANOR Nsg HOME -</b>  |                                 | d. STREET ADDRESS<br><b>3504 COURTLEIGH RD 21207</b>  |   |
| 3 NAME OF DECEASED<br>(Type or print)<br>First <b>Dora</b> Middle <b>Postels</b> Last <b>KY</b>   |                                 | 4 DATE OF DEATH<br>Month <b>12</b> Day <b>1</b> Year <b>1967</b>  |   |
| 5 SEX<br><b>Female</b>  | 6 COLOR OR RACE<br><b>White</b> | 7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>    | 8 DATE OF BIRTH <b>1892</b><br><b>5/12/XXXX</b> |
| 9 AGE (In years last birthday)<br><b>75</b> yrs   |                                 | 10 IF UNDER 1 YEAR<br>Months <b>1</b> Days <b>1</b> Hours <b>1</b> Min <b>1</b>   |   |
| 10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>MERCHANT</b>   |                                 | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>RETIRED</b>   |   |
| 11. BIRTHPLACE (County & State, or foreign country)<br><b>RUSSIA</b>  |                                 | 12 CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |   |
| 13. FATHER'S NAME<br><b>MORRIS HAMBURGER</b>  |                                 | 14 MOTHER'S MAIDEN NAME<br><b>SADIE ?</b>   |   |
| 15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><b>NO</b>   |                                 | 16 SOCIAL SECURITY NO<br><b>177-28-1566 A</b>   |   |
| 17 INFORMANT<br><b>MRS. SYLVIA CAPLAN, 3504 COURTLEIGH DRIVE</b>  |                                 | Address   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <b>Myocardial Infarction</b><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerosis</b><br>DUE TO<br>(c) |                                 | INTERVAL BETWEEN ONSET AND DEATH<br><b>minutes</b><br><b>continuous</b>   |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)  |                                 | 19 WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |   |
| 20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                                 | 20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I. of item 18)   |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. <b>19</b> p.m.  |                                 | 20d INJURY OCCURRED<br>Where <input type="checkbox"/> Not White <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/> |   |
| 20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc)  |                                 | 20f (City or town) (County) (State)   |   |
| 21. I certify that (1) (this hospital) attended the deceased from <b>11-13</b> , 19 <b>67</b> , to <b>12-1</b> , 19 <b>67</b> , that (1) (we) last saw the deceased alive on <b>11-20</b> , 19 <b>67</b> , and that death occurred at <b>1:10 P</b> M, from causes and on the date stated above                     |                                 |   |   |
| 22a. SIGNATURE<br><b>David D. Miller</b>  |                                 | 22b. DATE SIGNED<br><b>12-1-67</b>  |   |
| 22c. PHYSICIAN'S NAME (Type)<br><b>David D. Miller</b>  |                                 | 22d. ADDRESS<br><b>Linson Rd. Owings Mill, Md.</b>  |   |
| 23a BURIAL, CREMATION, REMOVAL (Specify)<br><b>REMOVAL-BURIAL</b>   |                                 | 23b DATE THEREOF<br><b>12-2-67</b>  |   |
| 23c NAME OF CEMETERY OR CREMATORY<br><b>ROOSEVELT</b>   |                                 | 23d LOCATION (City or Town) (County) (State)<br><b>PHILADELPHIA, PENNSYLVANIA</b>   |   |
| 24 FUNERAL DIRECTOR<br><b>SOL LEVINSON &amp; BROS. INC., 6010 REISTERSTOWN RD.</b>  |                                 | 25a REC'D BY REGISTRAR<br><b>DEC 5 1967</b>   |   |
|   |                                 | 25b REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>   |   |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.





16644

## CERTIFICATE OF DEATH

16637

|   |  |   |  |
|---|--|---|--|
| 1 PLACE OF DEATH<br>a COUNTY <b>Baltimore</b> MARYLAND  |  | 2 USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)<br>a STATE <b>Maryland</b> b COUNTY <b>Baltimore</b>               |  |
| b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Owings Mills</b>  |  | c LENGTH OF STAY IN 1b<br><b>23 months</b>  |  |
| d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>Rosewood State Hospital</b>   |  | e STREET ADDRESS<br><b>1420 School Lane</b>   |  |
| 3 NAME OF DECEASED (Type or print)<br>First <b>Doris</b> Middle <b>Marie</b> Last <b>PURVINES</b>   |  | 4 DATE OF DEATH<br>Month <b>12</b> Day <b>27</b> Year <b>19 67</b>  |  |
| 5 SEX<br><b>Female</b>  | 6 COLOR OR RACE<br><b>Negro</b>  | 7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>9-21-50</b>   |
| 9. AGE (In years last birthday)<br><b>17 yrs</b>  |  | 10. IF UNDER 1 YEAR<br>Months <b>12</b> Days <b>27</b> Hours <b>19</b> Min <b>67</b>  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Dependent</b>   |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>none</b>  |  |
| 11 BIRTHPLACE (County & State, or foreign country)<br><b>Baltimore City, Md.</b>  |  | 12 CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  |
| 13 FATHER'S NAME<br><b>Grant Leroy Purvines</b>   |  | 14 MOTHER'S MAIDEN NAME<br><b>Viola Henrietta Warner</b>  |  |
| 15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><b>no</b>   |  | 16. SOCIAL SECURITY NO<br><b>none</b>   |  |
| 17 INFORMANT<br><b>Rosewood Records, Owings Mills, Maryland</b>   |  | Address   |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Bronchopneumonia</b><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(b) <b>Acute Bronchitis</b><br>DUE TO<br>(c)<br>INTERVAL BETWEEN ONSET AND DEATH<br><b>2-3 days</b><br><b>Chronic</b> |  |   |  |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)<br><b>Cerebral Spastic Infantile Paralysis</b>  |  |   | 19 WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m. <b>19</b>  | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Not While <input type="checkbox"/><br>at work at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  | 20f. (City or town) (County) (State)   |
| 21. I certify that (I) (this hospital) attended the deceased from <b>1/11</b> , 19 <b>66</b> , to <b>12/27</b> , 19 <b>67</b> that (I) (we) last saw the deceased alive on <b>12/27</b> , 19 <b>67</b> , and that death occurred at <b>12:05 P.M.</b> from causes and on the date stated above.   |  |   |  |
| 22a SIGNATURE<br><i>Harry G. Butler</i>   |  | 22b. DATE SIGNED<br><b>12/27/67</b>   |  |
| 22c. PHYSICIAN'S NAME (Type)<br><b>Harry G. Butler, M.D.</b>  |  | 22d. ADDRESS<br><b>Rosewood St. Hosp., Owings Mills, Md.</b>  |  |
| 23a. BURIAL, CREMATION REMOVAL (Specify)<br><b>Burial</b>   | 23b. DATE THEREOF<br><b>12/31/67</b>   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Pleasant Rest</b>  | 23d. LOCATION (City or Town) (County) (State)<br><b>Towson, Balt. Co. Md.</b>                    |
| 24 FUNERAL DIRECTOR<br><b>Wm. J. Chaturanga - 1701 Mt. Calvary St.</b>  |  | 25a REC'D BY REGISTRAR<br><b>DATE DEC 29 1967</b>   |  |
| 25b REGISTRAR'S SIGNATURE   |  |   |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



16645

CERTIFICATE OF DEATH

15638

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

|   |  |   |  |
|---|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Baltimore</b> MARYLAND  |  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>                |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Parkville</b>  |  | c. LENGTH OF STAY IN 1b<br><b>Baltimore</b>   |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>8100 Harford Road</b>  |  | d. STREET ADDRESS<br><b>8501 School Road</b>  |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Elwood</b> Middle <b>LeRoy</b> Last <b>QUICKEL</b>  |  | 4. DATE OF DEATH<br>Month <b>December</b> Day <b>23</b> Year <b>1967</b>  |  |
| 5. SEX<br><b>Male</b>   | 6. COLOR OR RACE<br><b>White</b>   | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>July 31, 1904</b>   |
| 9. AGE (In years last birthday)<br><b>63 yrs</b>  |  | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Supervisor</b>   |  |
| 11. BIRTHPLACE (County & State or foreign country)<br><b>Penna.</b>   |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  |
| 13. FATHER'S NAME<br><b>Franklin Quickel</b>  |  | 14. MOTHER'S MAIDEN NAME<br><b>Nettie Hoke</b>  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><b>No</b>  |  | 16. SOCIAL SECURITY NO<br><b>213-10-9511</b>  |  |
| 17. INFORMANT<br><b>Mrs Anna E Quickel</b>  |  | Address<br><b>Same</b>  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Acute Coronary Occlusion</b><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) <b>Hypertensive Cardiovascular Endocarditis</b><br>DUE TO<br>(c) <b>Arteriosclerosis</b> |  |   | INTERVAL BETWEEN ONSET AND DEATH<br><b>2 months</b>                                    |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |  |   | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m. <b>19</b>  | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  | 20f. (City or town) (County) (State)   |
| 21. I certify that (I) (this hospital) attended the deceased from <b>April, 1956</b> , to <b>Dec., 1962</b> , that (I) (we) last saw the deceased alive on <b>12/23, 1962</b> , and that death occurred at <b>UNAM</b> , from causes and on the date stated above   |  |   |  |
| 22a. SIGNATURE<br><b>Dr. S. Elliott Harris</b>  |  | 22b. DATE SIGNED<br><b>12/23/62</b>   |  |
| 22c. PHYSICIAN'S NAME (Type)<br><b>Dr. S. Elliott Harris</b>  |  | 22d. ADDRESS<br><b>8100 Harford Road</b>  |  |
| 23a. BURIAL (CREMATION, REMOVAL (Specify))<br><b>Burial</b>   | 23b. DATE THEREOF<br><b>12/27/67</b>   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Parkwood</b>   | 23d. LOCATION (City or Town) (County) (State)<br><b>Baltimore Maryland</b>             |
| 24. FUNERAL DIRECTOR<br><b>Leonard J. Ruck, Inc. Balto. Md. 21214</b>   |  | 25a. REC'D BY REGISTRAR<br><b>DEC 27 1967</b>   |  |
| 25b. REGISTRAR'S SIGNATURE  |  |   |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 11-68  
30M REV 1-68

| MARYLAND STATE DEPARTMENT OF HEALTH<br>DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |  |                     |  |  |  |   |  |  |   |  |  |   |  |
|--|--|---------------------|--|--|--|---|--|--|---|--|--|---|--|
| CERTIFICATE OF DEATH   |  |                     |  |  |  |   |  |  |   |  |  |   |  |
| 1 DECEASED-NAME<br>(Type or print) <b>HUBERT L. RADCLIFFE</b>  |  |                     |  |  |  | 2a. DATE OF DEATH<br>Month <b>Dec.</b> Day <b>14</b> Year <b>1967</b>   |  |  | 2b. HOUR<br><b>12:30 PM</b>   |  |  |   |  |
| 3 SEX<br><b>M</b>  |  | 4. RACE<br><b>W</b> |  | 5. DATE OF BIRTH<br><b>JAN. 24, 1896</b> |  |   | 6. AGE (in years last birthday)<br><b>71</b> YRS |  | IF UNDER 1 YEAR<br>MONTHS <b>71</b> DAYS <b>71</b>                                |  | IF UNDER 24 HRS<br>HOURS <b>71</b> MIN <b>30</b> |   |  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>Md.</b>  |  |                     | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.</b>  |  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  | 9. COUNTY OF DEATH<br><b>BALTIMORE</b>  |  |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>CATONSVILLE</b>  |  |                     | 11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address)<br><b>SUMMIT HOME</b> |  |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>SHIP CAPTAIN</b>  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |  |   |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE <b>Md.</b>   |  |                     | 13b. COUNTY <b>BALTO.</b>  |  |  | 13c. CITY OR TOWN <b>CATONSVILLE</b>  |  |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  | 13e. STREET AND NUMBER<br><b>606 Edmondson Ave.</b> |  |
| 14. FATHER'S NAME First <b>George</b> Middle <b>W.</b> Last <b>Radcliffe</b>   |  |                     |  |  |  | 15. MOTHER'S MAIDEN NAME First <b>MARY</b> Middle <b>ELIZABETH</b> Last <b>RAPPANICK</b>  |  |  |   |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <b>NO</b>   |  |                     | 16b. SOCIAL SECURITY NO.<br><b>391-16-7154</b>   |  |  | 17. INFORMANT Address<br><b>VIOLA S. Radcliffe 606 Edmondson Ave.</b>   |  |  |   |  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |  |                     |  |  |  |   |  |  |   |  |  |   |  |
| PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Arteriosclerotic heart disease</b><br><b>+200</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____                                 |  |                     |  |  |  |   |  |  |   |  |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |                     |  |  |  |   |  |  |   |  |  |   |  |
| 19a. DATE OF OPERATION   |  |                     | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?              |  |  |   |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |  |                     | 21b. TIME OF INJURY<br>HOUR A.M. _____ Month _____ Day _____ Year _____<br>P.M. _____ 19 _____     |  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |  |   |  |  |   |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>   |  |                     | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                       |  |  | 21f. LOCATION Street or R.F.D. No. _____ City or Town _____ County _____ State _____  |  |  |   |  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>12/14, 1964</b> to <b>12/14, 1967</b> , that (I) (we) last saw the deceased alive on <b>12/14, 1967</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |                     |  |  |  |   |  |  |   |  |  |   |  |
| 22b. SIGNATURE<br><b>Robert A. Reiter, M.D.</b>  |  |                     |  |  |  | DEGREE <b>M.D.</b> ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>          |  |  | 22c. DATE SIGNED<br><b>12/16/67</b>   |  |  |   |  |
| 22d. PHYSICIAN'S NAME (Type)<br><b>Robert A. Reiter M.D.</b>   |  |                     |  |  |  | 22e. ADDRESS<br><b>606 Edmondson Ave 21228</b>  |  |  |   |  |  |   |  |
| 23a. BURIAL, CREMATION, <b>BURIAL</b><br>(Specify)   |  |                     | 23b. DATE<br><b>Dec. 18, 1967</b>  |  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>ST. Johns</b>  |  |  | 23d. LOCATION (City or Town) (County) (State)<br><b>HOWARD Md</b>                 |  |  |   |  |
| 24. FUNERAL DIRECTOR<br><b>E. B. MacNabb</b>   |  |                     |  |  |  | ADDRESS<br><b>301 Frederick Rd BALTO. 21228 Md.</b>   |  |  | 25a. REC'D BY REGISTRAR<br>DATE <b>DEC 18 1967</b>                                |  |  |   |  |
|  |  |                     |  |  |  | 25b. REGISTRAR'S SIGNATURE  |  |  |   |  |  |   |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

16647

16640

|   |                                     |  |   |
|---|-------------------------------------|--|---|
| 1 PLACE OF DEATH<br>a. COUNTY <b>Baltimore</b> MARYLAND   |                                     | 2 USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>                |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>For Howard</b>   |                                     | c. LENGTH OF STAY IN 1b<br><b>64 days</b>  |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>Veterans Administration Hospital</b>   |                                     | d. STREET ADDRESS<br><b>2632 Liberty Parkway</b>   |   |
| 3 NAME OF DECEASED<br>(Type or print) <b>EDWARD</b> First <b>HENRY</b> Middle <b>REINERT</b> Last   |                                     | 4. DATE OF DEATH<br>Month <b>December</b> Day <b>27</b> Year <b>19 67</b>  |   |
| 5 SEX<br><b>Male</b>  | 6 COLOR OR RACE<br><b>White</b>     | 7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | 8 DATE OF BIRTH<br><b>11/14/07</b>                                    |
| 9. AGE (In years last birthday)<br><b>60</b> yrs  |                                     | IF UNDER 1 YEAR<br>Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min <b>0</b>   |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Time Keeper</b>   |                                     | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Canning Industry</b>   |   |
| 11 BIRTHPLACE (County & State, or foreign country)<br><b>Chapman, Penna.</b>  |                                     | 12 CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |   |
| 13 FATHER'S NAME<br><b>Oliver Reinert</b>   |                                     | 14. MOTHER'S MAIDEN NAME<br><b>Minnie Wertz</b>  |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) (If yes give war or dates of service)<br><b>Yes WW-11</b>  |                                     | 16 SOCIAL SECURITY NO<br><b>213 07 84 62</b>   |   |
| 17 INFORMANT<br><b>Clinical Rcds, VA Hospital, Fort Howard, Md.</b>   |                                     | Address  |   |
| 18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c))<br>PART I DEATH WAS CAUSED BY.<br>IMMEDIATE CAUSE (a) <b>CARCINOMA OF LUNG</b><br>DUE TO<br>(b) <b>165X</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO<br>(c) |                                     |  |   |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br><b>EMPHYSEMA, RIGHT CHEST. BRONCHO PNEUMONIA, LEFT LUNG</b>   |                                     |  |   |
| 19 WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                                     |  |   |
| 20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                                     | 20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)  |   |
| 20c TIME OF INJURY Month, Day Year<br>Hour a.m. <b>19</b> p.m.  |                                     | 20d INJURY OCCURRED<br>While <input type="checkbox"/> Not While <input type="checkbox"/><br>at work of work  |   |
| 20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |                                     | 20f (City or town) (County) (State)  |   |
| 21. I certify that (X) (this hospital) attended the deceased from <b>Oct. 24</b> , 19 <b>67</b> , to <b>Dec. 27</b> 19 <b>67</b> , that (1) (X) we last saw the deceased alive on <b>Dec. 27</b> , 19 <b>67</b> , and that death occurred at <b>10:25</b> M, from causes and on the date stated above.  |                                     |  |   |
| 22a SIGNATURE<br><b>John D. Talbert</b>   |                                     | 22b. DATE SIGNED<br><b>12/27/67</b>  |   |
| 22c PHYSICIAN'S NAME (Type)<br><b>JOHN D. TALBERT, M.D.</b>   |                                     | 22d ADDRESS<br><b>VA Hospital, Fort Howard, Md.</b>  |   |
| 23a BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   | 23b DATE THEREOF<br><b>12/30/67</b> | 23c NAME OF CEMETERY OR CREMATORY<br><b>Oak Lawn Cemetery</b>  | 23d LOCAT ON (City or Town) (County) (State)<br><b>Baltimore, Md.</b> |
| 24 FUNERAL DIRECTOR<br><b>ULLRICH FUNERAL HOME</b>  |                                     | 25a REC'D BY REG. STAFF<br><b>JAN 5 1968</b>   |   |
| 25b REC'D BY REG. STAFF<br><b>James Judge</b>   |                                     |  |   |





# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME 15  
GM 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

16642

16641

|   |                             |  |   |  |  |   |   |
|---|-----------------------------|--|---|--|--|---|---|
| 1 PLACE OF DEATH<br>a. COUNTY <b>BALTO.</b> MARYLAND  |                             |  |   | 2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission)<br>a. STATE <b>MD.</b> b. COUNTY <b>BALTO</b> |  |   |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>ESSEX</b>  |                             | c. LENGTH OF STAY IN 1b  |   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>ESSEX</b>                                   |  |   |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>27 KERRIA LANE</b>   |                             |  |   | d. STREET ADDRESS<br><b>27 KERRIA LANE</b>   |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |
| 3 NAME OF DECEASED (Type or print)<br>First <b>SARAH</b> Middle <b>S.</b> Last <b>RICHARDSON</b>  |                             |  |   | 4 DATE OF DEATH<br>Month <b>DEC</b> Day <b>16</b> Year <b>1967</b>   |  |   |   |
| 5 SEX<br><b>F</b>   | 6 COLOR OR RACE<br><b>W</b> | 7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8 DATE OF BIRTH<br><b>AUG. 10, 1884</b> | 9 AGE (In years last birthday) yrs <b>83</b>   | IF UNDER 1 YEAR<br>Months Days Hours Min |   | IF UNDER 24 HRS<br>Hours Min  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)   |                             | 10b. KIND OF BUSINESS OR INDUSTRY  |   | 11 BIRTHPLACE (State or foreign country)<br><b>VIRGINIA</b>  |  | 12 CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |   |
| 13. FATHER'S NAME<br><b>SAFRIGHT</b>  |                             |  |   | 14. MOTHER'S MAIDEN NAME<br><b>P</b>   |  |   |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><b>NO</b>  |                             | 16. SOCIAL SECURITY NO<br><b>-</b>   |   | 17. INFORMANT<br><b>DAVID RICHARDSON</b> Address <b>13 COUNTRY CLUB LANE</b>   |  |   |   |
| 18. CAUSE OF DEATH (Enter only one cause per PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Acute Coronary Occlusion</b><br>+ 201 DUE TO <b>HCVD</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>U</b><br>(c)   |                             |  |   | INTERVAL BETWEEN ONSET AND DEATH   |  |   |   |
| PART I. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)   |                             |  |   |  |  |   | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH   |                             | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)   |   |  |  |   |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m. <b>19</b>  |                             | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> NOT While at work <input type="checkbox"/>  |   | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |  | 20f. (City or town) (County) (State)  |   |
| 21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |                             |  |   |  |  |   |   |
| ACTUAL SIGNATURE<br><b>Thomas C. Patterson</b>  |                             | EXAMINER'S NAME (Type)<br><b>THOMAS C. PATTERSON</b>   |   | M.D.   |  | 22. DATE SIGNED<br><b>12/18/67</b>  |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>  |                             | 23b. DATE THEREOF<br><b>12/18/67</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>DAK LAWN</b>  |  | 23d. LOCATION (City or Town) (County) (State)<br><b>BALTO. MD.</b>                                |   |
| 24. FUNERAL DIRECTOR<br><b>J.G. CONNELLY SONS</b>   |                             |  |   | ADDRESS<br><b>300 MACE</b>   |  | 25a. REC'D BY REGISTRAR<br><b>DATE DEC 20 1967</b>  |   |
|   |                             |  |   | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>   |  |   |   |



# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If only delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial transit permit. File pages 1 and 2 with the State Department of Health or its designated agent prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME  
6M 1/64

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

|   |                                 |  |  |
|---|---------------------------------|--|--|
| 1 PLACE OF DEATH<br>a. COUNTY <i>Baltimore</i> MARYLAND   |                                 | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <i>Md.</i> b. COUNTY <i>Balto.</i>                       |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><i>Uwings Mills</i>   |                                 | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><i>Uwings Mills</i>  |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><i>5 Pleasant Hill Road</i>   |                                 | d. STREET ADDRESS<br><i>5 Pleasant Hill Road</i>   |  |
| 3 NAME OF DECEASED (Type or print)<br><i>Wylie L. Ritchey Sr.</i>   |                                 | 4. DATE OF DEATH<br>Month <i>December</i> , Day <i>1</i> , Year <i>1967</i>  |  |
| 5 SEX<br><i>Male</i>  | 6 COLOR OR RACE<br><i>White</i> | 7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | 8 DATE OF BIRTH<br><i>August 8, 1905</i>   |
| 9 AGE (In years last birthday)<br><i>62</i> yrs   |                                 | 10 IF UNDER 1 YEAR<br>Months <i>03</i> , Days <i>1</i>   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><i>Lawyer</i>  |                                 | 10b. KIND OF BUSINESS OR INDUSTRY  |  |
| 11. BIRTHPLACE (State or foreign country)<br><i>Balto. City</i>   |                                 | 12 CITIZEN OF WHAT COUNTRY<br><i>USA</i>   |  |
| 13 FATHER'S NAME<br><i>Michael W. Ritchey</i>   |                                 | 14 MOTHER'S MAIDEN NAME<br><i>Bessie Laughlin</i>  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><i>No</i>  |                                 | 16. SOCIAL SECURITY NO<br><i>214-38-4084</i>   |  |
| 17 INFORMANT<br><i>Mr. Wylie L. Ritchey Jr.</i>   |                                 | Address<br><i>Uwings Mills, Md.</i>  |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Angina Pectoris</i><br>- 202<br>DUE TO<br>Arteriosclerotic C-V Dis.<br>Conditions if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b)<br>(c)  |                                 |  | INTERVAL BETWEEN ONSET AND DEATH<br><i>6 mo.</i><br><br><i>1 yr.</i>                             |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)   |                                 |  | 19 WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br><i>none</i>   |                                 | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. <i>none</i> p.m. <i>19</i>  |                                 | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)                            |
| 20f. (City or town)   |                                 | 20g. (County) (State)  |  |
| 21 I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |                                 |  |  |
| ACTUAL SIGNATURE<br><i>D. D. Caples</i>   |                                 | CHIEF MEDICAL EXAMINER <input type="checkbox"/>  |  |
| EXAMINER'S NAME (Type)<br><i>D. D. Caples, M. D.</i>  |                                 | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>  |  |
| DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>   |                                 | 22. DATE SIGNED<br><i>12-2-67</i>  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><i>Burial</i>  |                                 | 23b. DATE THEREOF<br><i>Dec. 4, 67</i>   |  |
| 23c. NAME OF CEMETERY OR CREMATORY<br><i>All Saints Cemetery</i>  |                                 | 23d. LOCATION (City or Town) (County) (State)<br><i>Reisterstown, Md.</i>  |  |
| 24. FUNERAL DIRECTOR<br><i>J. F. Eline &amp; Sons</i>   |                                 | ADDRESS<br><i>Reisterstown, Md.</i>  |  |
| 25a. REC'D BY REGISTRAR<br>DATE <i>DEC 4 1967</i>   |                                 | 25b. REGISTRAR'S SIGNATURE<br><i>Charles Judge</i>   |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

| 16650  |  | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  | 16643   |  |
|--|--|--|--|---|--|
| CERTIFICATE OF DEATH   |  |  |  |   |  |
| 1. PLACE OF DEATH<br>a. COUNTY <b>Baltimore</b><br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rosedale Rural</b><br>c. LENGTH OF STAY IN 1b <b>45 yrs</b><br>d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>1236 Spring Avenue</b> |  | 2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)<br>a. STATE <b>Md.</b><br>b. COUNTY <b>Baltimore</b><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b><br>d. STREET ADDRESS <b>1236 Spring Avenue 2237</b><br>e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |   |  |
| 3. NAME OF DECEASED<br>(Type or print) <b>William A. Ritter</b>  |  | 4. DATE OF DEATH<br>Month <b>12</b> Day <b>18</b> Year <b>1967</b>   |  |   |  |
| 5. SEX <b>Male</b> 6. COLOR OR RACE <b>Cau</b> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>  |  | 8. DATE OF BIRTH <b>11-17-1881</b> 9. AGE (In years last birthday) <b>86</b> yrs   |  | 10. IF UNDER 1 YEAR Months <b>12</b> Days <b>18</b> Hours <b>16</b> Min.  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Own business</b>  |  | 10b. KIND OF BUSINESS OR INDUSTRY <b>Hardware</b>  |  | 11. BIRTHPLACE (County & State or foreign country) <b>Baltimore, Md.</b> 12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b> |  |
| 13. FATHER'S NAME <b>William A. Ritter</b>   |  | 14. MOTHER'S MAIDEN NAME <b>Martha McCullough</b>  |  |   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>  |  | 16. SOCIAL SECURITY NO <b>216-32-8381</b>  |  | 17. INFORMANT <b>Mrs Clara M. Ritter</b> Address <b>1237 1236 Spring Avenue</b>                                     |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Acute Nontraumatic Hemorrhage</b><br>DUE TO (b)<br>DUE TO (c)<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.            |  | INTERVAL BETWEEN ONSET AND DEATH   |  |   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |  | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>  |  |   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)   |  |   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. <b>19</b> p.m. <b>19</b>   |  | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>   |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)   |  |
| 20f. (City or town) (County) (State)   |  |  |  |   |  |
| 21. I certify that (I) (this hospital) attended the deceased from <b>12/20, 1966</b> to <b>12/18, 1967</b> , that (I) (we) saw the deceased alive on <b>12/17, 1967</b> , and that death occurred at <b>7:4 A.M.</b> from causes and on the date stated above.   |  |  |  |   |  |
| 22a. SIGNATURE <b>John G. Orth, M.D.</b>   |  | 22b. DATE SIGNED <b>12/19/67</b>   |  |   |  |
| 22c. PHYSICIAN'S NAME (Type)   |  | 22d. ADDRESS   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>  |  | 23b. DATE THEREOF <b>12-20-1967</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY <b>Parkwood Cemetery</b>   |  |
| 23d. LOCATION (City or Town) <b>Baltimore, Co.</b>   |  | (County) <b>Md.</b>  |  | (State)   |  |
| 24. FUNERAL DIRECTOR <b>Lassahn Funeral Home</b>   |  | 25a. REC'D BY REGISTRAR <b>DEC 22 1967</b>   |  | 25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>   |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

| MARYLAND STATE DEPARTMENT OF HEALTH  |                                 |   |                                   |
|--|---------------------------------|---|-----------------------------------|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |                                 |   |                                   |
| 16651  |                                 | 16644   |                                   |
| 1 PLACE OF DEATH   |                                 | 2 USUAL RESIDENCE (Where deceased lived if institution. Residence before admission)   |                                   |
| a. COUNTY<br><b>BALTIMORE</b>  |                                 | a. STATE<br><b>MARYLAND</b>   |                                   |
| b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town)<br><b>FORT HOWARD</b>  |                                 | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>BALTIMORE - 21223</b>  |                                   |
| c. LENGTH OF STAY IN lb<br><b>42 DAYS</b>  |                                 | d. STREET ADDRESS<br><b>212 N. GILMORE STREET</b>   |                                   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>VETERANS ADMINISTRATION HOSPITAL</b>  |                                 | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |                                   |
| 3 NAME OF DECEASED (Type or print)   |                                 | 4 DATE OF DEATH   |                                   |
| First Middle Last<br><b>JAMES R. ROBINSON</b>  |                                 | Month Day Year<br><b>DECEMBER 12 19 67</b>  |                                   |
| 5 SEX<br><b>MALE</b>   | 6 COLOR OR RACE<br><b>NEGRO</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>1/5/09</b> |
| 9 AGE (In years last birthday)<br><b>58 yrs</b>  |                                 | 10. IF UNDER 1 YEAR<br>Months Days Hours Min  |                                   |
| 11. BIRTHPLACE (County & State, or foreign country)<br><b>WHITEHALL, MARYLAND</b>  |                                 | 12. (IT ZEN OF WHAT COUNTRY?)<br><b>U.S.A.</b>  |                                   |
| 13. FATHER'S NAME<br><b>CALVIN ROBINSON</b>  |                                 | 14. MOTHER'S MAIDEN NAME<br><b>GRACE DAVIS</b>  |                                   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><b>YES WW II</b>  |                                 | 16. SOCIAL SECURITY NO.<br><b>203 01 11 43</b>  |                                   |
| 17. INFORMANT<br><b>CLIN. RECORDS, VA HOSPITAL, FT HOWARD, MD.</b>   |                                 | Address   |                                   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>HEPATIC COMA</b><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>CIRRHOSIS OF LIVER</b><br>DUE TO<br>(c) |                                 | INTERVAL BETWEEN ONSET AND DEATH<br><b>UNKNOWN</b>  |                                   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |                                 | 19. WAS A Topsy PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |                                   |
| 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                                 | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1B.)   |                                   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m. <b>19</b>   |                                 | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>   |                                   |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |                                 | 20f. (City or town) (County) (State)  |                                   |
| 21. I certify that (X) (this hospital) attended the deceased from <b>10/30/67</b> , 19__, to <b>12/12/67</b> , that (X) (we) last saw the deceased alive on <b>12/12/67</b> , 19__, and that death occurred at <b>10:30AM</b> , from causes and on the date stated above   |                                 |   |                                   |
| 22a. SIGNATURE<br><i>John D. Talbert</i>   |                                 | 22b. DATE SIGNED<br><b>12/12/67</b>   |                                   |
| 22c. PHYSICIAN'S NAME (Type)<br><b>JOHN D. TALBERT, M. D.</b>  |                                 | 22d. ADDRESS<br><b>VAH FORT HOWARD, MARYLAND</b>  |                                   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>   |                                 | 23b. DATE THEREOF<br><b>12-15-67</b>  |                                   |
| 23c. NAME OF CEMETERY OR CREMATORY<br><b>BALTIMORE NATIONAL</b>  |                                 | 23d. LOCATON (City or Town) (County) (State)<br><b>BALTIMORE, MARYLAND</b>  |                                   |
| 24. FUNERAL DIRECTOR<br><b>MARTEN &amp; DYETTE FUNERAL HOME</b>  |                                 | 25a. REC'D BY REGISTRAR<br><b>DEC 15 1967</b>   |                                   |
| 25b. REGISTRAR'S SIGNATURE<br><i>Charles Judge</i>   |                                 |   |                                   |





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4-67)  
25M 1/67

| MARYLAND STATE DEPARTMENT OF HEALTH  |  |   |  |
|--|--|---|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |   |  |
| CERTIFICATE OF DEATH   |  |   |  |
| 10545  |  |   |  |
| 1. PLACE OF DEATH<br>a. COUNTY<br><b>Baltimore</b><br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Towson</b><br>c. LENGTH OF STAY IN 1b<br><b>03-</b>   |  | 2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission)<br>a. STATE<br><b>Maryland</b><br>b. COUNTY<br><b>Baltimore 21206</b> |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>ST. JOSEPH HOSPITAL</b>   |  | d. STREET ADDRESS<br><b>421 Bucks School House Rd.</b><br>e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>            |  |
| 3. NAME OF DECEASED<br>(Type or print)<br><b>Joseph Marshal ROHE</b>   |  | 4. DATE OF DEATH<br>Month <b>December</b> Day <b>22</b> Year <b>19 67</b>   |  |
| 5. SEX<br><b>Male</b>  | 6. COLOR OR RACE<br><b>White</b>   | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>January 25, 1889</b>                                |
| 9. AGE (In years last birthday)<br><b>78 yrs</b>   |  | IF UNDER 1 YEAR<br>Months <b>78</b> Days <b>78</b> Hours <b>78</b> Min. <b>78</b>   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Selfemployed</b>   |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Store</b>   |  |
| 11. BIRTHPLACE (County & State, or foreign country)<br><b>Baltimore, Maryland</b>  |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  |
| 13. FATHER'S NAME<br><b>John Rohe</b>  |  | 14. MOTHER'S MAIDEN NAME<br><b>Ellen Dougherty</b>  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><b>No</b>   |  | 16. SOCIAL SECURITY NO<br><b>218-32-3191</b>  |  |
| 17. INFORMANT<br><b>Mr Joseph C. Rohe 414 F. Shirley Avenue</b>  |  | Address <b>21206</b>  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Myocardial infarction</b><br>DUE TO (b) <b>coronary thrombosis secondary to coronary arteriosclerosis.</b><br>DUE TO (c) <b>arteriosclerosis.</b>                        |  |   |  |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br>19. WAS AUTOPSY PERFORMED?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  |   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour <b>o.m.</b> 19<br>p.m.  | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Not While <input type="checkbox"/><br>at work at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  | 20f. (City or town) (County) (State)                                       |
| 21. I certify that <b>NO</b> (this hospital) attended the deceased from <b>12/2/</b> , 19 <b>67</b> , to <b>12/22/</b> , 19 <b>67</b> that <b>4</b> (we) last saw the deceased alive on <b>12/22/</b> , 19 <b>67</b> , and that death occurred at <b>9:55</b> M, from causes and on the date stated above. |  |   |  |
| 22a. SIGNATURE<br><b>William</b>   |  | 22b. DATE SIGNED<br><b>12/22/67</b>   |  |
| 22c. PHYSICIAN'S NAME (Type)<br><b>Ines Cilliani, M.D.</b>   |  | 22d. ADDRESS<br><b>7620 York Rd., Towson, Md. 21204</b>   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   | 23b. DATE THEREOF<br><b>12-26-1967</b>   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>St. Joseph's Cemetery</b>  | 23d. LOCATION (City or Town) (County) (State)<br><b>Baltimore, Co. Md.</b> |
| 24. FUNERAL DIRECTOR<br><b>Lasson Funeral Home 7401 Belair Road</b>  |  | 25a. REC'D BY REGISTRAR<br><b>36</b><br>DATE <b>DEC 27 1967</b>   |  |
| 25b. REGISTRAR'S SIGNATURE<br><b>James Judge</b>   |  |   |  |



## CERTIFICATE OF DEATH

16653

15646

|   |  |  |   |
|---|--|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Baltimore</u> MARYLAND  |  | 2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission)<br>a. STATE <u>Maryland</u> b. COUNTY <u>1</u>                     |   |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>   |  | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>  |   |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>6800 Liberty Road</u>   |  | d. STREET ADDRESS <u>6800 Liberty Road</u>   |   |
| 3. NAME OF DECEASED (Type or print) <u>MILTON ROSEMAN</u>   |  | 4. DATE OF DEATH <u>DECEMBER 6 19 67</u>   |   |
| 5. SEX <u>Male</u>  | 6. COLOR OR RACE <u>White</u>  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>Sept. 21, 1906</u>        |
| 9. AGE (in years last birthday) <u>61</u> yrs.  |  | 10. IF UNDER 1 YEAR Months Days Hours Min.   |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Comptroller</u>  |  | 10b. KIND OF BUSINESS OR INDUSTRY <u>Liquor</u>  |   |
| 11. BIRTHPLACE (County & State or foreign country) <u>Baltimore, Md.</u>  |  | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u>  |   |
| 13. FATHER'S NAME <u>Aaron Roseman</u>  |  | 14. MOTHER'S MAIDEN NAME <u>Mary Kaplan</u>  |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)   |  | 16. SOCIAL SECURITY NO.  |   |
| 17. INFORMANT <u>Mrs. Lillian Roseman 6800 Liberty Rd</u>   |  | Address  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Carcinoma of stomach, abdominal</u><br>1550 DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Carcinoma of colon</u><br>DUE TO<br>(c) |  | INTERVAL BETWEEN ONSET AND DEATH <u>3 mo</u><br><u>3 mo</u>  |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)   |  | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>  |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)   |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m. <u>19</u>  | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   | 20f. (City or town) (County) (State)          |
| 21. I certify that (I) (this hospital) attended the deceased from <u>Apr 11, 1959</u> to <u>Dec 6, 1967</u> , that (I) (we) last saw the deceased alive on <u>Dec 4, 1967</u> , and that death occurred on <u>4:20 P.M.</u> from causes and on the date stated above.   |  |  |   |
| 22a. SIGNATURE <u>Dr. Irvin Sauber</u> M.D.   |  | 22b. DATE SIGNED <u>Dec 6, 67</u>  |   |
| 22c. PHYSICIAN'S NAME (Type) <u>Dr. Irvin Sauber</u>  |  | 22d. ADDRESS <u>6905 Park Heights Avenue</u>   |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>   | 23b. DATE THEREOF <u>12-8-67</u>   | 23c. NAME OF CEMETERY OR CREMATORY <u>Mikro Kodesh Beth Israel Baltimore, Maryland</u>   | 23d. LOCATION (City or town) (County) (State) |
| 24. FUNERAL DIRECTOR <u>Sol Levinson &amp; Bros. 6010 Reisterstown Rd.</u>  |  | 25a. REC'D BY REGISTRAR <u>DEC 12 1967</u>   |   |
| 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>   |  |  |   |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

16654

15647

|  |                           |  |                                       |  |  |   |  |
|--|---------------------------|--|---------------------------------------|--|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Balto.</u> MARYLAND  |                           |  |                                       | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)<br>e. STATE <u>Md.</u> b. COUNTY <u>Balto.</u> |  |   |  |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Rural - Parkton</u>  |                           |  |                                       | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Rural - Parkton</u>                              |  |   |  |
| c. LENGTH OF STAY IN 1b <u>7 1/2 yrs.</u>  |                           |  |                                       | d. STREET ADDRESS <u>Cameron Mill Rd.</u>  |  |   |  |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Cameron Mill Rd.</u>   |                           |  |                                       | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                       |  |   |  |
| 3. NAME OF DECEASED (Type or print) <u>Harry</u>   |                           | First <u>Harry</u> Middle <u>Rosier</u> Last <u>Rosier</u>   |                                       | 4. DATE OF DEATH <u>12 - 26</u>  |  | Year <u>1967</u>  |  |
| 5. SEX <u>M</u>  | 6. COLOR OR RACE <u>W</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>Jan. 12, 1896</u> | 9. AGE (In years last birthday) <u>71</u> yrs.   | IF UNDER 1 YEAR Months <u>12</u> Days <u>26</u> Hours <u>12</u> Min. <u>00</u> | IF UNDER 24 HRS. Months <u>12</u> Days <u>26</u> Hours <u>12</u> Min. <u>00</u> |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Trackman</u>  |                           | 10b. KIND OF BUSINESS OR INDUSTRY <u>Railroad</u>  |                                       | 11. BIRTHPLACE (County & State, or foreign country) <u>Balto. Co, Md.</u>  |  | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>                                      |  |
| 13. FATHER'S NAME <u>unknown</u>   |                           |  |                                       | 14. MOTHER'S MAIDEN NAME <u>Dorcas Ann Rosier</u>  |  |   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No.</u>   |                           | 16. SOCIAL SECURITY NO. <u>717-07-6768</u>   |                                       | 17. INFORMANT <u>Minnie Rosier, Parkton, Md. R.R.</u>  |  |   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>C. A. C. V. Disease</u><br>7131 DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____<br>INTERVAL BETWEEN ONSET AND DEATH _____ |                           |  |                                       |  |  |   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                           |  |                                       | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. _____ p.m. <u>19</u>   |                           | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>   |                                       | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |  | 20f. (City or town) _____ (County) _____ (State) _____                          |  |
| 21. I certify that (I) (this hospital) attended the deceased from <u>1950</u> to <u>12/27</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>12/26</u> , 19 <u>67</u> , and that death occurred at <u>1:00</u> M, from the causes and on the date stated above.  |                           |  |                                       |  |  |   |  |
| 22a. SIGNATURE <u>A. M. France</u>   |                           |  |                                       | 22b. DATE SIGNED <u>12/28/67</u>   |  | 22c. PHYSICIAN'S NAME (Type) <u>A. M. FRANCE</u>                                |  |
| 22c. PHYSICIAN'S NAME (Type) <u>A. M. FRANCE</u>   |                           | 22d. ADDRESS <u>PARKTON, Md.</u>   |                                       | 22e. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>   |  | 22f. ATTENDING PHYS. <input checked="" type="checkbox"/>                        |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>  |                           | 23b. DATE THEREOF <u>12/29/67</u>  |                                       | 23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Zion Cem.</u>  |  | 23d. LOCATION (City, town or county) <u>Freeland Md.</u> (State) _____          |  |
| 24. FUNERAL DIRECTOR <u>S. Jacob Hartenstein, New Freedom, Pa.</u>   |                           |  |                                       | 25a. REC'D BY REGISTRAR <u>DATE JAN 2 1968</u>   |  | 25b. REGISTRAR'S SIGNATURE <u>Philip A. ...</u>                                 |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (pages 1 and 2) and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

16655

16648

|   |                           |  |                                 |
|---|---------------------------|--|---------------------------------|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Baltimore</u> MARYLAND  |                           | 2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)<br>a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>              |                                 |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>   |                           | c. LENGTH OF STAY IN 1b <u>38 yrs.</u>   |                                 |
| c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>   |                           | d. STREET ADDRESS <u>4 Catonsville, Md</u>   |                                 |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Spring Grove State Hospital</u>   |                           | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |                                 |
| 3. NAME OF DECEASED (Type or print) First <u>Sohn</u> Middle <u>Henry</u> Last <u>Rothenberger</u>  |                           | 4. DATE OF DEATH Month <u>12</u> Day <u>31</u> Year <u>1967</u>  |                                 |
| 5. SEX <u>M</u>   | 6. COLOR OR RACE <u>W</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>9/16/98</u> |
| 9. AGE (In years last birthday) <u>69</u> yrs   |                           | 10. IF UNDER 1 YEAR Months Days Hours M.n  |                                 |
| 11. BIRTHPLACE (County & State or foreign country) <u>Balto. Md.</u>  |                           | 12. CITIZEN OF WHAT COUNTRY? <u>United States</u>  |                                 |
| 13. FATHER'S NAME <u>Peter J. Rothenberger</u>  |                           | 14. MOTHER'S MAIDEN NAME <u>Mammie Stumpf</u>  |                                 |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>   |                           | 16. SOCIAL SECURITY NO. <u>chart</u>   |                                 |
| 17. INFORMANT <u>chart</u>  |                           | Address  |                                 |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))<br>PART I. DEATH WAS CAUSED BY.<br>IMMEDIATE CAUSE (a) <u>pulmonary edema</u><br>DUE TO<br>Conditions if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <u>probable repeated myocardial infarction</u><br>DUE TO<br>(c) <u>coronary insufficiency</u> |                           | INTERVAL BETWEEN ONSET AND DEATH: <u>~10 mins</u><br><u>3 days</u><br><u>10 months</u>   |                                 |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>chronic schizophrenia; mental retardation</u>  |                           | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |                                 |
| 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <u>NO</u>  |                           | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II at item 18.)  |                                 |
| 20c. TIME OF INJURY Month, Day Year <u>19</u>   |                           | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work   |                                 |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |                           | 20f. (City or town) (County) (State)   |                                 |
| 21. I certify that (I) (this hospital) attended the deceased from <u>June 25, 1935</u> , to <u>12/31, 1967</u> , that (I) (we) last saw the deceased alive on <u>12/31, 1967</u> , and that death occurred at <u>1:08 AM</u> , from causes and on the date stated above   |                           |  |                                 |
| 22a. SIGNATURE <u>Ann Louise Silver</u>   |                           | 22b. DATE SIGNED <u>12/31/67</u>   |                                 |
| 22c. PHYSICIAN'S NAME (Type) <u>Ann Louise Silver, M.D.</u>   |                           | 22d. ADDRESS <u>Spring Grove State Hospital</u>  |                                 |
| 23a. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>  |                           | 23b. DATE THEREOF <u>1/3/68</u>  |                                 |
| 23c. NAME OF CEMETERY OR CREMATORY <u>Holy Cross Cemetery</u>   |                           | 23d. LOCATION (City or Town) (County) (State) <u>Brooklyn, Md.</u>   |                                 |
| 24. FUNERAL DIRECTOR <u>Schimmunek Funeral Home, Inc.</u>   |                           | 25a. REC'D BY REGISTRAR <u>JAN 3 1968</u>  |                                 |
| ADDRESS <u>3331 Brehms Lane</u>   |                           | 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>  |                                 |





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in with the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

16656

13649

|  |                                  |   |                                    |  |  |   |   |
|--|----------------------------------|---|------------------------------------|--|--|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Baltimore</u> MARYLAND   |                                  |   |                                    | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> |  |   |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Catonsville</u>   |                                  | c. LENGTH OF STAY IN 1b<br><u>1 yr 3 1/2 mos</u>  |                                    | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Baltimore</u> 30                                      |  |   |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><u>Forest Haven Nurs Home 315 Ingleside Ave</u>  |                                  |   |                                    | d. STREET ADDRESS<br><u>514 Old Orchard Rd</u>   |  |   |   |
| 3. NAME OF DECEASED<br>(Type or print)<br>First <u>ETHEL</u> Middle <u>L.</u> Last <u>Rowan</u>  |                                  |   |                                    | 4. DATE OF DEATH<br>Month <u>12</u> Day <u>14</u> Year <u>1967</u>   |  |   |   |
| 5. SEX<br><u>Female</u>  | 6. COLOR OR RACE<br><u>white</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><u>3-13-93</u> | 9. AGE (In years last birthday) <u>74</u> yrs  | 10. IF UNDER 24 HRS<br>Months <u>12</u> Days <u>14</u> Hours <u>19</u> Min <u>67</u> |   |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Housewife</u>  |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>home</u>  |                                    | 11. BIRTHPLACE (County & State, or foreign country)<br><u>Missouri</u>   |  | 12. CITIZEN OF WHAT COUNTRY?<br><u>USA</u>                                  |   |
| 13. FATHER'S NAME<br><u>John Doyle</u>   |                                  |   |                                    | 14. MOTHER'S MAIDEN NAME<br><u>Nettie Shelley</u>  |  |   |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES (Yes, no, or unknown) (If yes give war or dates of service)<br><u>NO</u>  |                                  | 16. SOCIAL SECURITY NO<br><u>494-18-2581</u>  |                                    | 17. INFORMANT<br>Address <u>Mrs Mahala A. Rowan 514 Old Orchard</u>  |  |   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Myocardial infarction</u><br>DUE TO (b) <u>Arteriosclerosis (Hypertension)</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) <u>Arteriosclerosis</u><br>DUE TO (c) <u>Arteriosclerosis</u> |                                  |   |                                    |  |  |   | INTERVAL BETWEEN ONSET AND DEATH  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART (a)  |                                  |   |                                    |  |  |   | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                                  |   |                                    | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part or Part I of item 18)  |  |   |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour <u>19</u> o.m. <u>19</u> p.m.   |                                  | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/> |                                    | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |  | 20f. (City or town) (County) (State)  |   |
| 21. I certify that (I) (the hospital) attended the deceased from <u>12/11</u> , 19 <u>66</u> to <u>12/19</u> , 19 <u>66</u> , that (I) (we) saw the deceased alive on <u>12/14</u> , 19 <u>67</u> , and that death occurred at <u>7:00 A.M.</u> from causes and on the date stated above.  |                                  |   |                                    |  |  |   |   |
| 22a. SIGNATURE<br><u>John A. Shaw</u>  |                                  |   |                                    | M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>            |  | 22b. DATE SIGNED<br><u>12/18/67</u>   |   |
| 22c. PHYSICIAN'S NAME (Type)<br><u>John A. Shaw M.D.</u>   |                                  |   |                                    | 22d. ADDRESS<br><u>5700 Enochson Ave Baltimore</u>   |  |   |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial</u>   |                                  | 23b. DATE THEREOF<br><u>Dec 16, 1967</u>  |                                    | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Lorraine Park Cemt.</u>   |  | 23d. LOCATION (City or Town) (County) (State)<br><u>Baltimore, Maryland</u> |   |
| 24. FUNERAL DIRECTOR<br><u>STERLING FUNERAL ESTATE</u>   |                                  |   |                                    | ADDRESS<br><u>736 Edm. Av Catonsville</u>  |  | 25a. REC'D BY REGISTRAR<br>DATE <u>DEC 18 1967</u>                          |   |
|  |                                  |   |                                    | 25b. REGISTRAR'S SIGNATURE<br><u>Charles J. George</u>   |  |   |   |



## CERTIFICATE OF DEATH

16650

|  |   |  |  |
|--|---|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>BALTIMORE</b> MARYLAND   |   | 2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission)<br>a. STATE <b>MARYLAND</b> b. COUNTY <b>—</b>                     |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>PIKESVILLE</b>   |   | c. LENGTH OF STAY IN 1b <b>104</b>   |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>MILFORD MANOR NURSING HOME</b>   |   | d. STREET ADDRESS <b>3008 FALLSTAFF MANOR CT.</b>  |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>ISRAEL</b> Middle <b>RUCK</b> Last <b>RUCK</b>   |   | 4. DATE OF DEATH<br>Month <b>DECEMBER</b> Day <b>24</b> Year <b>1967</b>   |  |
| 5. SEX <b>MALE</b>   | 6. COLOR OR RACE <b>WHITE</b>   | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <b>JUNE 10, 1892</b>  |
| 9. AGE (in years last birthday) <b>75</b> yrs  |   | 10. IF UNDER 1 YEAR: Months <b>—</b> Days <b>—</b> Hours <b>—</b> Min <b>—</b>   |  |
| 11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>GROCERY</b>   |   | 11b. KIND OF BUSINESS OR INDUSTRY <b>RETIRED</b>   |  |
| 12. BIRTHPLACE (County & State, or foreign country) <b>POLAND</b>  |   | 13. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>   |  |
| 14. FATHER'S NAME <b>UNKNOWN</b>   |   | 15. MOTHER'S MAIDEN NAME <b>UNKNOWN</b>  |  |
| 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>NO</b>  |   | 17. SOCIAL SECURITY NO <b>216-28-7002</b>  |  |
| 18. INFORMANT <b>MRS. ROSE RUCK, 3008 FALLSTAFF MANOR CT. #9</b>   |   | Address <b>—</b>   |  |
| 19. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Carcinoma of pancreas</b><br>DUE TO <b>157X</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost:<br>(b) <b>—</b><br>(c) <b>—</b> |   |  | INTERVAL BETWEEN ONSET AND DEATH <b>6 months</b>   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>None</b>  |   |  | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)   |   | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1B)   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. <b>19</b> p.m. <b>—</b>  | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)  | 20f. (City or town) (County) (State)   |
| 21. I certify that (I) (this hospital) attended the deceased from <b>June 1, 1966</b> to <b>Dec 24, 1967</b> , that (I) (we) saw the deceased alive on <b>Dec 24, 1967</b> , and that death occurred at <b>11 A.M.</b> from causes and on the date stated above  |   |  |  |
| 22a. SIGNATURE <b>Manuel Levin</b>   |   | 22b. DATE SIGNED <b>12/24/67</b>   |  |
| 22c. PHYSICIAN'S NAME (Type) <b>MANUEL LEVIN M.D.</b>  |   | 22d. ADDRESS <b>1101 PARK HEIGHTS AVE BALTO MD</b>   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>  | 23b. DATE THEREOF <b>12-26-67</b>   | 23c. NAME OF CEMETERY OR CREMATORY <b>CHIZUK AMINO</b>   | 23d. LOCATION (City or Town) (County) (State) <b>BALTIMORE, MARYLAND</b>                       |
| 24. FUNERAL DIRECTOR <b>SOL LEVINSON &amp; BROS., 6010 REISTERSTOWN ROAD</b>   |   | 25a. REC'D BY REGISTRAR <b>DATE DEC 28 1967</b>  |  |
| 25b. REGISTRAR'S SIGNATURE   |   |  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



## CERTIFICATE OF DEATH

16651

16656

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

|  |                               |   |   |
|--|-------------------------------|---|---|
| 1 PLACE OF DEATH<br>a. COUNTY <u>Baltimore</u> MARYLAND  |                               | 2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)<br>a. STATE <u>Maryland</u> b. COUNTY <u>✓</u>                          |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>  |                               | c. LENGTH OF STAY IN 1b   |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, write street address) <u>Home</u>  |                               | d. STREET ADDRESS <u>6109 Park Heights Ave</u>  |   |
| 3 NAME OF DECEASED (Type or print)<br>First <u>BARNETT</u> Middle <u>H.</u> Last <u>RUDO</u>   |                               | 4. DATE OF DEATH<br>Month <u>Dec.</u> Day <u>31</u> Year <u>1967</u>  |   |
| 5. SEX <u>Male</u>   | 6. COLOR OR RACE <u>White</u> | 7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>  | 8 DATE OF BIRTH<br><u>JULY 15, 1884</u> |
| 9 AGE (n years last birthday) <u>83</u> yrs  |                               | 10 IF UNDER 1 YEAR<br>Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min <u>  </u>   |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>   |                               | 10b. KIND OF BUSINESS OR INDUSTRY <u>Real Estate</u>  |   |
| 11 BIRTHPLACE (County & State, or foreign country) <u>Russia</u>   |                               | 12 CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>   |   |
| 13 FATHER'S NAME <u>HYMAN</u> <u>Rudo</u>  |                               | 14 MOTHER'S MAIDEN NAME <u>REBECCA</u> ? <u>One</u>   |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes give war or dates of service)  |                               | 16 SOCIAL SECURITY NO. <u>  </u>  |   |
| 17. INFORMANT <u>Mrs Elsie Rudo-6109 Park Hts</u>  |                               | Address <u>  </u>   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>CARDIAC FAILURE</u><br>DUE TO <u>4221</u><br>Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause lost. (b) <u>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</u><br>DUE TO <u>  </u><br>(c) <u>  </u> |                               | INTERVAL BETWEEN ONSET AND DEATH <u>Immediate</u><br><u>YEARS</u>   |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>AZOTEMIA</u>   |                               | 19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <u>NO</u>   |                               | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <u>  </u>  |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. <u>  </u> p.m. <u>19</u>   |                               | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/> |   |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>  </u>   |                               | 20f. (City or town) <u>  </u> (County) <u>  </u> (State) <u>  </u>  |   |
| 21. I certify that (1) (this hospital) attended the deceased from <u>NOV</u> , 19 <u>67</u> , to <u>31 Dec</u> , 19 <u>67</u> , that (1) (we) last saw the deceased alive on <u>30 Dec</u> , 19 <u>67</u> , and that death occurred at <u>12:00</u> AM, from causes and on the date stated above   |                               |   |   |
| 22a. SIGNATURE <u>Malcolm S Druskin</u> M.D.   |                               | 22b. DATE SIGNED <u>31 Dec 67</u>   |   |
| 22c. PHYSICIAN'S NAME (Type) <u>MALCOLM S DRUSKIN, MD</u>  |                               | 22d. ADDRESS <u>2217 SOUTH ROAD, BALTO 9, MD</u>  |   |
| 23a. BURIAL, CREMATION, OR REMOVAL (Specify) <u>Burial</u>   |                               | 23b. DATE THEREOF <u>Jan 2/68</u>   |   |
| 23c. NAME OF CEMETERY OR CREMATORY <u>Bethel Hebrew</u>  |                               | 23d. LOCAT ON (City or Town) (County) (State) <u>Baltimore, Md</u>  |   |
| 24. FUNERAL DIRECTOR <u>Sol Leunson &amp; Sons Inc</u> ADDRESS <u>6000 Kew-Forest Road</u>   |                               | 25a. REC'D BY REGISTRAR <u>  </u> 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>   |   |
| DATE <u>4 1968</u>   |                               |   |   |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20 M 1/66

16659

CERTIFICATE OF DEATH

16652

|   |  |  |  |
|---|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Baltimore</u><br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Towson 4</u><br>c. LENGTH OF STAY IN 1b<br><u>4</u><br>d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><u>St. Joseph Hospital</u>   |  | 2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission)<br>a. STATE <u>Maryland</u><br>b. COUNTY <u>Baltimore</u><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Baltimore 21213</u><br>d. STREET ADDRESS<br><u>3423 Ramona Avenue</u><br>e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 3. NAME OF DECEASED (Type or print)<br>First <u>AMANDA</u> Middle <u>RUNDBERG</u> Last<br>4. DATE OF DEATH <u>December 16, 1967</u>   |  | 5. SEX <u>Female</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> B. DATE OF BIRTH <u>August 17, 1897</u> 9. AGE (In years last birthday) <u>70</u> yrs   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Housewife</u>   |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>at home</u>  |  |
| 11. BIRTHPLACE (County & State, or foreign country)<br><u>Sweden</u>  |  | 12. CITIZENSHIP OF WHAT COUNTRY?<br><u>U.S.A.</u>  |  |
| 13. FATHER'S NAME<br><u>August Larson</u>   |  | 14. MOTHER'S MAIDEN NAME<br><u>unknown</u>   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><u>551-28-9370B</u>  |  | 16. SOCIAL SECURITY NO.<br><u>551-28-9370B</u>   |  |
| 17. INFORMANT<br><u>Fred Rundberg, son, 5616 Ready Ave.</u>   |  | Address  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))<br>PART I. DEATH WAS CAUSED BY<br><u>4221</u> IMMEDIATE CAUSE (a) <u>Congestive heart failure</u><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(b) <u>Arteriosclerotic cardiovascular disease</u><br>DUE TO<br>(c) |  | INTERVAL BETWEEN ONSET AND DEATH   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |  | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m. <u>19</u>  |  | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/><br>at work at work  |  |
| 20e. PLACE OF INJURY (Home, farm, factory street, office bldg., etc.)   |  | 20f. (City or town) (County) (State)   |  |
| 21. I certify that <del>he</del> (this hospital) attended the deceased from <u>December 9, 1967</u> , to <u>December 16, 1967</u> that <del>he</del> (we) last saw the deceased alive on <u>December 16, 1967</u> , and that death occurred at <u>7:30 AM</u> , from causes and on the date stated above.   |  |  |  |
| 22a. SIGNATURE<br><u>Antonio De Leon, M.D.</u>  |  | 22b. DATE SIGNED<br><u>December 16, 1967</u>   |  |
| 22c. PHYSICIAN'S NAME (Type)<br><u>Antonio De Leon, M.D.</u>  |  | 22d. ADDRESS<br><u>7620 York Road, Towson 4, Md.</u>   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial</u>  |  | 23b. DATE THEREOF<br><u>12/19/67</u>   |  |
| 23c. NAME OF CEMETERY OR CREMATORY<br><u>Gardens of Faith Cem.</u>  |  | 23d. LOCATION (City or Town) (County) (State)<br><u>Baltimore, Md.</u>   |  |
| 24. FUNERAL DIRECTOR<br><u>Schumnek Funeral Home, Inc.</u><br><u>3331 Brehms Lane</u>   |  | 25a. REC'D BY REGISTRAR<br>DATE <u>DEC 21 1967</u>   |  |
| 25b. REGISTRAR'S SIGNATURE<br><u>Charles Judge</u>  |  |  |  |





# FOR STATE HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (S)  
6M 1/67

## MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 Item 8 Film G396 1/2/68 13r MEDICAL EXAMINER'S CERTIFICATE OF DEATH

|  |                                      |  |   |
|--|--------------------------------------|--|---|
| 1 PLACE OF DEATH<br>a. COUNTY <b>Baltimore</b> MARYLAND  |                                      | 2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>                 |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)   |                                      | c. LENGTH OF STAY IN 1b  |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>St. Joseph Hospital</b>   |                                      | d. STREET ADDRESS<br><b>528 Walker Avenue, 21212</b>   |   |
| 3 NAME OF DECEASED (Type or print)<br><b>JOSEPH FRANCIS SADUSK, SR.</b>  |                                      | 4 DATE OF DEATH<br>Month <b>December</b> Day <b>16</b> Year <b>19 67</b>   |   |
| 5 SEX<br><b>Male</b>   | 6 COLOR OR RACE<br><b>White</b>      | 7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>W DOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8 DATE OF BIRTH<br><b>12-28-86 85</b>   |
| 9 AGE (In years and birthday)<br><b>81</b> y's   |                                      | 10 UNDER 1 YEAR<br>Months <b>12</b> Days <b>16</b> Hours <b>00</b> Min <b>00</b>   | 11 OVER 24 HRS<br>Months <b>12</b> Days <b>16</b> Hours <b>00</b> Min <b>00</b> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Retired</b>  |                                      | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Tailor</b>   |   |
| 11 BIRTHPLACE (State or foreign country)<br><b>Lithuania</b>   |                                      | 12 CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |   |
| 13. FATHER'S NAME<br><b>Francis Sadusk</b>   |                                      | 14 MOTHER'S MAIDEN NAME<br><b>Unknown</b>  |   |
| 15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><b>no</b>  |                                      | 16 SOCIAL SECURITY NO<br><b>213-09-5608</b>  |   |
| 17 INFORMANT<br><b>Wife - Eva M.</b>   |                                      | Address<br><b>same</b>   |   |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <b>Cardiac Arrest</b><br>DUE TO <b>Sudden</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost<br>(b) <b>Shock</b><br>DUE TO <b>Sudden</b><br>(c) <b>Multiple Fractures and Internal Injuries</b><br>INTERVAL BETWEEN ONSET AND DEATH<br><b>Sudden</b>                |                                      |  |   |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTE TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br><b>Family Transmission Not in Evidence</b>   |                                      |  |   |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTE <input type="checkbox"/><br>CAUSE OF DEATH<br><b>Struck by Automobile</b>   |                                      | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)<br><b>Family Transmission Not in Evidence</b>                   |   |
| 20c. TIME OF INJURY Month, Day, Year<br><b>12-16 1967</b>  |                                      | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>  |   |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office, etc.)<br><b>Street</b>  |                                      | 20f. (City or town) (County) (State)<br><b>Baltimore City, Maryland</b>  |   |
| 21 I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> |                                      |  |   |
| ACTUAL SIGNATURE<br><b>Charles F. O'Donnell, M.D.</b>  |                                      | 22 DATE SIGNED<br><b>12/16/67</b>  |   |
| EXAMINER'S NAME (Type)<br><b>Charles F. O'Donnell, M.D.</b>  |                                      | Address (Street, city, town, or county)<br><b>Baltimore</b>  |   |
| 23a. BURIAL CREMATION, REMOVAL (Specify)<br><b>Burial</b>  | 23b. DATE THEREOF<br><b>12/20/67</b> | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Holy Redeemer Cemetery</b>  |   |
| 24 FUNERAL DIRECTOR<br><b>Mitchell-Wiedefeld Home-6500 York Road-21212</b>   |                                      | 25a. REC'D BY REGISTRAR<br><b>DEC 29 1967</b>  |   |
| 25b. REGISTRAR'S SIGNATURE   |                                      |  |   |

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

|  |  |   |  |
|--|--|---|--|
| 16662  |  | 16655   |  |
| 1. PLACE OF DEATH<br>a. COUNTY <u>BALTO</u> MARYLAND   |  | 2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission)<br>a. STATE <u>MD.</u> b. COUNTY <u>BALTO.</u>                        |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>STEVENSON</u>   | c. LENGTH OF STAY IN 1b  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>STEVENSON</u>  |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><u>VILLA JULIE</u>   |  | d. STREET ADDRESS<br><u>VALLEY ROAD.</u>  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print)<br>First Middle Last<br><u>SISTER ELIZABETH ST. PETER</u>  |  | 4. DATE OF DEATH<br>Month Day Year<br><u>DEC. 15 19 67</u>  |  |
| 5. SEX<br><u>F</u>   | 6. COLOR OR RACE<br><u>W</u>   | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><u>JULY 12, 1883</u>   |
| 9. AGE (In years last birthday)<br><u>84</u> yrs   |  | 10. IF UNDER 1 YEAR<br>Months Days Hours Min.   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>TEACHER</u>  |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>RELIGIOUS</u>   | 11. BIRTHPLACE (County & State, or foreign country)<br><u>IRELAND</u>                  |
| 12. CITIZEN OF WHAT COUNTRY?<br><u>U.S.A.</u>  |  | 13. FATHER'S NAME<br><u>PETER MCGIRR</u>  |  |
| 14. MOTHER'S MAIDEN NAME<br><u>ELIZABETH QUINN</u>   |  | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><u>NO</u>  |  |
| 16. SOCIAL SECURITY NO<br><u>---</u>   |  | 17. INFORMANT<br><u>Sister Bernard Marie - Villa Julie</u>  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))<br>PART I. DEATH WAS CAUSED BY.<br>IMMEDIATE CAUSE (a) <u>Cerebral Accidents.</u><br>331X<br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost<br>(b) <u>arteriosclerotic vascular disease</u><br>DUE TO<br>(c) <u>years</u> |  | INTERVAL BETWEEN ONSET AND DEATH<br><u>48 hrs</u>   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |  | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1B)  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o.m. p.m. 19  | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  | 20f. (City or town) (County) (State)   |
| 21. I certify that (I) (this hospital) attended the deceased from <u>Feb.</u> , 19 <u>63</u> , to <u>Dec 15</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>Nov 14 1967</u> , and that death occurred at <u>1230 P.M.</u> from causes and on the date stated above.   |  |   |  |
| 22a. SIGNATURE<br><u>Harold H Burns</u>  |  | 22b. DATE SIGNED<br><u>12-15-1967</u>   |  |
| 22c. PHYSICIAN'S NAME (Type)<br><u>8106 Haywood Rd.</u>  |  | 22d. ADDRESS  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial</u>   |  | 23b. DATE THEREOF<br><u>12-18-67</u>  | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Trinity Cemetery and</u>                      |
| 23d. LOCATION (City or Town) (County) (State)<br><u>Dcheater Md.</u>   |  | 24. FUNERAL DIRECTOR<br><u>Jrley. Conway to Fr. Antonio...</u>  |  |
| 25a. REC'D BY REGISTRAR<br><u>DEC 26 1967</u>  |  | 25b. REGISTRAR'S SIGNATURE<br><u>Francis J. Judge</u>   |  |



## CERTIFICATE OF DEATH

16661

13654

|   |                                 |   |   |
|---|---------------------------------|---|---|
| 1 PLACE OF DEATH<br>a COUNTY <u>Baltimore</u> MARYLAND  |                                 | 2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)<br>a STATE <u>Maryland</u> b COUNTY <u>Baltimore</u>                      |   |
| b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Ruxton</u>  |                                 | c LENGTH OF STAY IN lb<br>c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Ruxton</u>                                    |   |
| d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><u>6509 Darnell Rd.</u>  |                                 | e IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |   |
| 3 NAME OF DECEASED<br>(Type or print) <u>James Mumford Sawhill</u>  |                                 | 4 DATE OF DEATH<br>Month <u>December</u> Day <u>22</u> Year <u>1967</u>   |   |
| 5 SEX<br><u>Male</u>  | 6 COLOR OR RACE<br><u>White</u> | 7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>    | 8 DATE OF BIRTH<br><u>April 7, 1905</u> |
| 9 AGE (In years last birthday) <u>62</u> yrs  |                                 | IF UNDER 1 YEAR<br>Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min <u>  </u>  |   |
| 10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Vice President</u>   |                                 | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>Alloy Cladding Co</u>   |   |
| 11 BIRTHPLACE (County & State, or foreign country)<br><u>Ohio</u>   |                                 | 12 CITIZEN OF WHAT COUNTRY?<br><u>U.S.A.</u>  |   |
| 13. FATHER'S NAME<br><u>James E. Sawhill</u>  |                                 | 14 MOTHER'S MAIDEN NAME<br><u>Elizabeth Moore</u>   |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) (If yes give war or dates of service)<br><u>No</u>   |                                 | 16. SOCIAL SECURITY NO.<br><u>284-07-4452</u>   |   |
| 17 INFORMANT<br><u>Mrs. Mary G. Sawhill</u>   |                                 | Address<br><u>Same</u>  |   |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u><br>DUE TO<br>(b) <u>Coronary arteriosclerosis</u><br>DUE TO<br>(c) <u>  </u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |                                 | INTERVAL BETWEEN ONSET AND DEATH<br><u>1 min</u>  |   |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)   |                                 | 19 WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |   |
| 20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                                 | 20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)   |   |
| 20c TIME OF INJURY Month, Day, Year<br>Hour a.m. <u>  </u> p.m. <u>19</u>   |                                 | 20d INJURY OCCURRED<br>While <input type="checkbox"/> Not While <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/> |   |
| 20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |                                 | 20f (City or town) (County) (State)   |   |
| 21. I certify that (I) (this hospital) attended the deceased from <u>Feb 3, 1947</u> to <u>December 22, 1967</u> that (I) (we) last saw the deceased alive on <u>  </u> 19 <u>  </u> , and that death occurred at <u>  </u> M, from causes and on the date stated above.  |                                 |   |   |
| 22a. SIGNATURE<br><u>Charles Holmes Boyd</u> M.D.   |                                 | 22b DATE SIGNED   |   |
| 22c PHYSICIAN'S NAME (Type)<br><u>Dr. C. Holmes Boyd</u>  |                                 | 22d ADDRESS   |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial</u>  |                                 | 23b DATE THEREOF<br><u>12-26-67</u>   |   |
| 23c NAME OF CEMETERY OR CREMATORY<br><u>Druid Ridge</u>   |                                 | 23d LOCATION (City or Town) (County) (State)<br><u>Pikesville, Md.</u>  |   |
| 24 FUNERAL DIRECTOR<br><u>Mitchell-Wiedefeld Home, Inc. 6500 York Rd. Baltimore, Md. 21212</u>  |                                 | 25 REGISTRAR'S SIGNATURE<br><u>Charles J. Jorg</u>  |   |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16663

## CERTIFICATE OF DEATH

13856

|   |   |  |  |
|---|---|--|--|
| 1 PLACE OF DEATH<br>a. COUNTY <b>Baltimore</b><br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Towson 4</b><br>c. LENGTH OF STAY IN 1b   |   | 2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission)<br>a. STATE <b>Maryland</b><br>b. COUNTY <b>Baltimore-21234</b><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>St. Joseph Hospital</b>  |   | d. STREET ADDRESS<br><b>1918 Wildwood Avenue</b><br>e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |
| 3 NAME OF DECEASED (Type or print)<br>First <b>ALBERT</b> Middle <b>SCHAIBLE</b> Last   |   | 4 DATE OF DEATH<br>Month <b>December</b> Day <b>2</b> Year <b>19 67</b>  |  |
| 5. SEX<br><b>Male</b>   | 6. COLOR OR RACE<br><b>White</b>  | 7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>   | 8 DATE OF BIRTH<br><b>November 27, 1881</b>                                  |
| 9 AGE (In years last birthday) <b>86</b> yrs  |   | 10 UNDER 1 YEAR<br>Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min.   | 11 CITIZEN OF WHAT COUNTRY?<br><b>U.S. A.</b>                                |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Bookkeeper</b>  |   | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Office</b>   |  |
| 11. BIRTHPLACE (County & State, or foreign country)<br><b>Brooklyn, New York</b>  |   | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S. A.</b>   |  |
| 13. FATHER'S NAME<br><b>Henry Schaible</b>  |   | 14. MOTHER'S MAIDEN NAME<br><b>Dora ?</b>  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><b>No</b>  |   | 16 SOCIAL SECURITY NO<br><b>218-12-0800</b>  |  |
| 17. INFORMANT<br><b>Mrs. Florence Schaible</b>  |   | Address<br><b>Above</b>  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Heart failure</b><br>DUE TO <b>Anemia</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. }<br>(b)<br>(c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) |   |  | INTERVAL BETWEEN ONSET AND DEATH   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. <b>19</b> p.m.  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   | 20f. (City or town) (County) (State)   |
| 21. I certify that <del>he</del> (this hospital) attended the deceased from <b>November 24, 1967</b> , to <b>December 2, 1967</b> , that <del>he</del> (we) last saw the deceased alive on <b>December 2, 1967</b> , and that death occurred at <b>9:10 a.m.</b> , from causes and on the date stated above.  |   |  |  |
| 22a. SIGNATURE<br><i>I. Gillian</i>   |   | 22b. DATE SIGNED<br><b>December 2, 1967</b>  |  |
| 22c. PHYSICIAN'S NAME (Type) <b>Inez Gilliani, M.D.</b>   |   | 22d. ADDRESS<br><b>7620 York Road, Towson, Md. 21204</b>   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  | 23b. DATE THEREOF<br><b>12-5-67</b>   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Parkwood</b>  | 23d. LOCATION (City or Town) (County) (State)<br><b>Parkville Balto. Md.</b> |
| 24. FUNERAL DIRECTOR<br><b>H.W. Jenkins &amp; Sons Co.</b>  |   | 25a. REC'D BY REGISTRAR<br><b>DEC 5 1967</b>   |  |
| 25b. REGISTRAR'S SIGNATURE<br><i>Charles Judge</i>  |   |  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.





**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201**

**CERTIFICATE OF DEATH**

16664

16657

|  |                              |   |                                    |  |  |   |   |
|--|------------------------------|---|------------------------------------|--|--|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Baltimore</u> MARYLAND   |                              |   |                                    | 2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)<br>a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>  |  |   |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Baltimore-Catonsville</u>   |                              | c. LENGTH OF STAY IN 1b<br><u>15 days</u>   |                                    | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Baltimore</u>   |  |   |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><u>Spring Grove State Hospital</u>   |                              |   |                                    | d. STREET ADDRESS<br><u>1120 Ingleside Ave</u>   |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   |
| 3. NAME OF DECEASED (Type or print)<br>First <u>Charles</u> Middle <u>A.</u> Last <u>Schaum</u>  |                              |   |                                    | DATE OF DEATH<br>Month <u>12</u> Day <u>31</u> Year <u>1967</u>  |  |   |   |
| 5. SEX<br><u>M</u>   | 6. COLOR OR RACE<br><u>W</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><u>11/7/84</u> |  | 9. AGE (In years last birthday)<br><u>83</u> yrs | IF UNDER 1 YEAR<br>Months <u>  </u> Days <u>  </u>  | IF UNDER 24 HRS.<br>Hours <u>  </u> Min <u>  </u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>CONFECTION</u>   |                              | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>CONFECTION</u>  |                                    | 11. BIRTHPLACE (County & State, or foreign country)<br><u>New York</u>   |  | 12. CITIZEN OF WHAT COUNTRY?<br><u>United States</u>  |   |
| 13. FATHER'S NAME<br><u>Jacob Schaum</u>   |                              |   |                                    | 14. MOTHER'S MAIDEN NAME<br><u>Catherine</u>   |  |   |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><u>NO</u>   |                              | 16. SOCIAL SECURITY NO.<br><u>213-03-5801</u>   |                                    | 17. INFORMANT<br><u>chart</u> Address <u>SPRING GROVE ST. HOSPITAL</u>   |  |   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>cardiac ischemia</u><br>DUE TO <u>4201</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. }<br>(b) <u>pneumonia</u><br>DUE TO<br>(c) <u>  </u> |                              |   |                                    |  |  | INTERVAL BETWEEN ONSET AND DEATH<br><u>1 day</u><br><u>3 days</u>   |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br><u>Diabetes mellitus - adult onset; chronic brain syndrome</u>  |                              |   |                                    |  |  | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)<br><u>NO</u>   |                              | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)<br><u>  </u>  |                                    | 20c. TIME OF INJURY Month, Day, Year<br>Hour <u>  </u> a.m. <u>  </u> p.m. <u>19</u>   |  | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/> |   |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)<br><u>  </u>  |                              | 20f. (City or town) (County) (State)<br><u>  </u>   |                                    | 21. I certify that (1) (this hospital) attended the deceased from <u>Dec 16, 1967</u> to <u>Dec 31, 1967</u> that (1) (we) last saw the deceased alive on <u>Dec 30, 1967</u> , and that death occurred at <u>4:25 AM</u> , from causes and on the date stated above |  |   |   |
| 22a. SIGNATURE<br><u>Ann Louise Silver</u>   |                              | M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>                          |                                    | 22b. DATE SIGNED<br><u>12/31/67</u>  |  |   |   |
| 22c. PHYSICIAN'S NAME (Type)<br><u>Ann Louise Silver, M.D.</u>   |                              | 22d. ADDRESS<br><u>Spring Grove State Hospital</u>  |                                    |  |  |   |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>BURIAL</u>   |                              | 23b. DATE THEREOF<br><u>1-3-1968</u>  |                                    | 23c. NAME OF CEMETERY OR CREMATORY<br><u>GARDENS OF FAITH</u>  |  | 23d. LOCATION (City or town) (County) (State)<br><u>BALTIMORE MARYLAND</u>  |   |
| 24. FUNERAL DIRECTOR<br><u>WEBER FUNERAL HOME 5311 EDMONDSON AVE</u>   |                              | 25a. REC'D BY REGISTRAR<br>DATE <u>JAN 2 1968</u>   |                                    | 25b. REGISTRAR'S SIGNATURE<br><u>Charles Judge</u>   |  |   |   |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, and 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

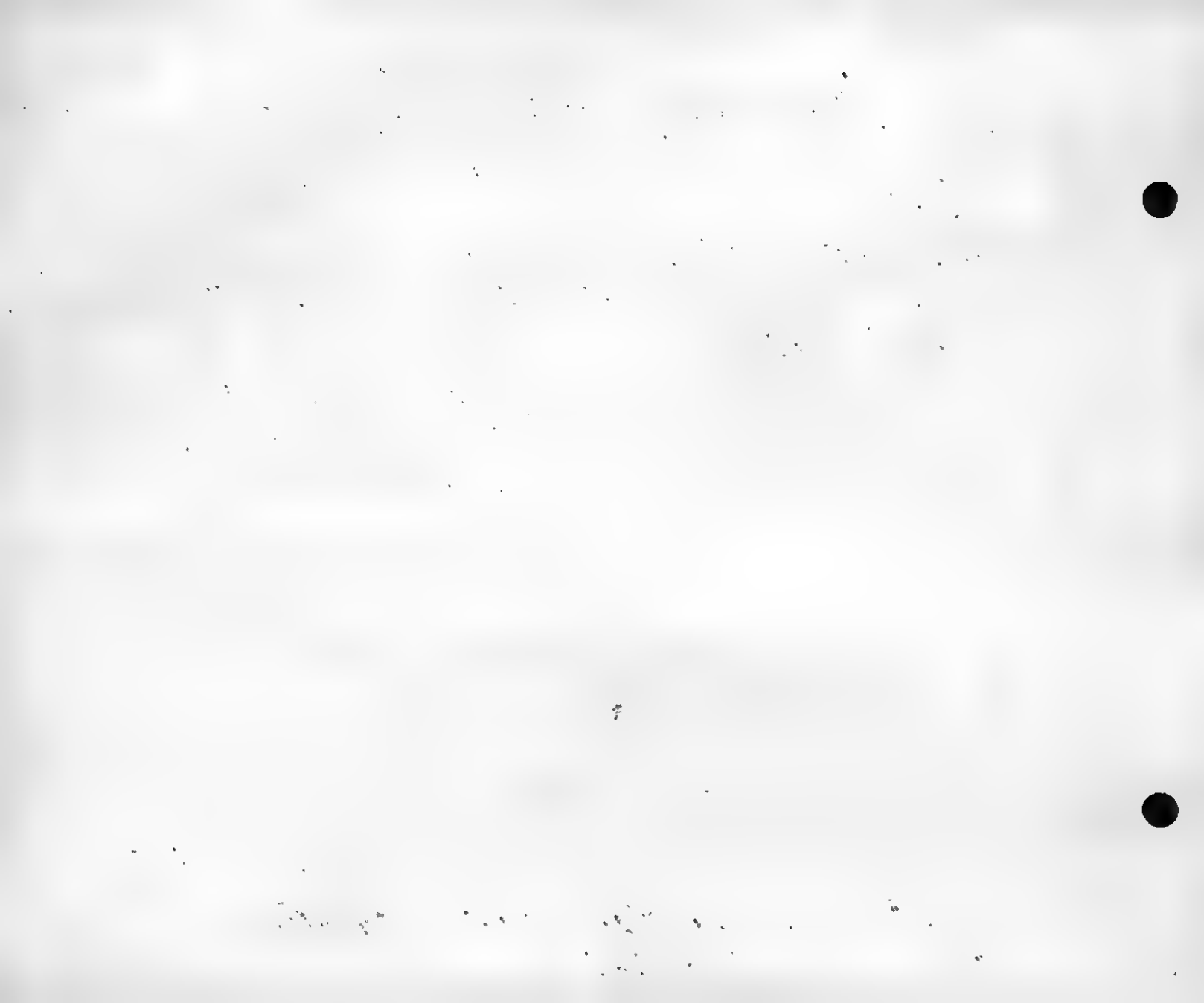
16665

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

16658

|   |  |   |   |   |   |  |   |   |   |  |  |
|---|--|---|---|---|---|--|---|---|---|--|--|
| 1. DECEASED-NAME<br>(Type or print) <i>Elizabeth Schneider</i>  |  |   | 2a. DATE OF DEATH<br>Month <i>12</i> Day <i>22</i> Year <i>67</i>   |   |   | 2b. HOUR<br><i>3:45 AM</i>   |   |   |   |  |  |
| 3. SEX<br><i>F</i>  |  | 4. RACE<br><i>W</i>                         |   | 5. DATE OF BIRTH<br><i>Apr. 6, 87</i>   |   | 6. AGE (In years<br>lost birthday)<br><i>80</i> YRS  |   | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN                                |   |  |  |
| 7a. BIRTHPLACE (State or foreign<br>country) <i>Balto</i>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><i>U.S.</i> |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. COUNTY OF DEATH<br><i>Balto</i> Md  |   |   |   |  |  |
| 10. CITY OR TOWN OF DEATH<br><i>Balto Md</i>  |  |   | 11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital<br>give street address) <i>1300 Harford Hill Rd</i> |   |   | 12a. USUAL OCCUPATION (Kind of work done<br>during most of work ng life, even if retired)  |   |   | 12b. KIND OF BUSINESS OR<br>INDUSTRY                  |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before<br>admission) STATE <i>Md</i>  |  |   | 13b. COUNTY<br><i>Balto</i>   |   | 13c. CITY OR TOWN<br><i>Balto</i>                     |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 13e. STREET AND NUMBER<br><i>1300 Harford Hill Rd</i> |  |  |
| 14. FATHER'S NAME First <i>Carl</i> Middle <i>Wilhelm</i> Last  |  |   | 15. MOTHER'S MAIDEN NAME First <i>Anna</i> Middle <i>?</i> Last   |   |   |  |   |   |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or (unknown) (If yes give war or dates of service)   |  |   | 16b. SOCIAL SECURITY NO   |   | 17. INFORMANT<br><i>Daughter</i>                      |  |   | Address <i>Same</i>   |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Carcinoma of the face (epidermal) with</i><br><i>1970</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave<br>rise to immediate cause (a),<br>stating the underlying cause<br>last. (b) <i>metastases to neck + chest</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <i>2 years</i> |  |   |   |   |   |  |   |   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH       |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |   |   |   |   |  |   |   |   |  |  |
| 19a. DATE OF OPERATION  |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING<br>CAUSES OF DEATH? |   |  |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  |  |   | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <i>19</i>   |   |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)   |   |   |   |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>  |  |   | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,<br>OFFICE BUILDING, ETC.)                             |   |   | 21f. LOCATION Street or R.F.D. No. City or Town County State   |   |   |   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>December, 1957</i> to <i>Dec 22</i> , 19 <i>67</i> , that (I) (we) last<br>saw the deceased alive on <i>Dec 22</i> , 19 <i>67</i> , and that in (my) (our) opinion death occurred on the date and hour and from the<br>causes stated above. (I) (we) (did) (did not) view the body after death.   |  |   |   |   |   |  |   |   |   |  |  |
| 22b. SIGNATURE<br><i>Stellman</i>   |  |   |   |   |   | DEGREE ATTENDING<br>PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF<br>PHYS. <input type="checkbox"/> |   | 22c. DATE SIGNED  |   |  |  |
| 22d. PHYSICIAN'S<br>NAME (Type)   |  |   |   |   |   | 22e. ADDRESS<br><i>6217 Harford Rd Baltimore Md</i>  |   |   |   |  |  |
| 23a. BURIAL, CREMATION,<br>REMOVAL (Specify)  |  |   | 23b. DATE<br><i>12/23/67</i>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><i>Eastwood</i> |  | 23d. LOCATION (City or town)<br><i>Balto Md</i>   |   | (County) (State)                                      |  |  |
| 24. FUNERAL DIRECTOR<br><i>W. Stellman</i>  |  |   |   |   |   | ADDRESS<br><i>6067 Harf Rd</i>   |   | 25a. REC'D BY REGISTRAR<br>DATE <i>DEC 27 1967</i>                      |   | 25b. REGISTRAR'S SIGNATURE<br><i>Judge</i> |  |



## CERTIFICATE OF DEATH

156511

|  |                                      |  |  |
|--|--------------------------------------|--|--|
| 1 PLACE OF DEATH<br>a. COUNTY <b>Baltimore</b><br>MARYLAND   |                                      | 2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>               |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Fort Howard</b>   |                                      | c. LENGTH OF STAY IN lb<br><b>122 days</b>   |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>Veterans Administration Hospital</b>  |                                      | e. STREET ADDRESS<br><b>1316 E Fort Avenue</b>   |  |
| 3 NAME OF DECEASED<br>(Type or print) <b>JOHN</b> First Middle Last <b>----- SCHNUIT</b>   |                                      | 4. DATE OF DEATH <b>December 14 19 67</b> Month Day Year   |  |
| 5 SEX<br><b>Male</b>   | 6 COLOR OR RACE<br><b>White</b>      | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>3/6/09</b>  |
| 9. AGE (in years last birthday) yrs. <b>58</b>   |                                      | 10. IF UNDER 1 YEAR IF UNDER 24 HRS<br>Months Days Hours Min   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Stevodore</b>  |                                      | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Shipping</b>   |  |
| 11. BIRTHPLACE (County & State, or foreign country)<br><b>Baltimore, Maryland</b>  |                                      | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  |
| 13. FATHER'S NAME<br><b>Martin Schnuit</b>   |                                      | 14. MOTHER'S MAIDEN NAME<br><b>Wilhelmina Picker</b>   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><b>Yes WW-11</b>  |                                      | 16. SOCIAL SECURITY NO<br><b>217 05 89 86</b>  |  |
| 17. INFORMANT<br><b>Clinical Rcds, VA Hospital, Fort Howard Md.</b>  |                                      | Address  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>THROMBOSIS, RIGHT MIDDLE CEREBRAL ARTERY</b><br>332.X<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) <b>CEREBRAL ARTERIOSCLEROSIS</b><br>(c)     |                                      |  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)<br><b>AMYOTROPHIC LATERAL SCLEROSIS</b>   |                                      |  |  |
| 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                                      |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                                      | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m. <b>19</b>   |                                      | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Not While <input type="checkbox"/><br>at work at work   |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |                                      | 20f. (City or town) (County) (State)   |  |
| 21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>Aug. 14, 19 67</b> to <b>Dec. 14, 19 67</b> that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>Dec. 14 19 67</b> , and that death occurred at <b>6:55 a.m.</b> from causes and on the date stated above. |                                      |  |  |
| 22a. SIGNATURE<br><b>J. D. Talbert</b>   |                                      | 22b. DATE SIGNED<br><b>12/14/67</b>  |  |
| 22c. PHYSICIAN'S NAME (Type)<br><b>J. D. TALBERT, M.D.</b>   |                                      | 22d. ADDRESS<br><b>VA Hospital, Fort Howard, Md.</b>   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   | 23b. DATE THEREOF<br><b>12/18/67</b> | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Woodlawn Cemetery</b>   | 23d. LOCATION (City or Town) (County) (State)<br><b>Baltimore Maryland</b> |
| 24. FUNERAL DIRECTOR<br><b>Charles L. Stevens, Inc.</b>  |                                      | 25a. RECEIVED BY REGISTRAR<br><b>DEC 19 1967</b>   |  |
| 25b. REGISTRAR'S SIGNATURE<br><b>Judge</b>   |                                      |  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



16667

## CERTIFICATE OF DEATH

16660

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

|   |   |   |   |
|---|---|---|---|
| 1 PLACE OF DEATH<br>a. COUNTY <u>Maryland Baltimore</u> MARYLAND  |   | 2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)<br>a. STATE <u>Maryland</u><br>b. COUNTY <u>Baltimore</u>               |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Pikesville</u>   |   | c. LENGTH OF STAY IN 1b<br><u>Baltimore</u>   |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><u>Miford Manor Nursing Home</u>  |   | d. STREET ADDRESS<br><u>1701 Eutaw Place</u>  |   |
| 3. NAME OF DECEASED<br>(Type or print)<br><u>Dora Oppenheimer Schorsch</u>  |   | 4. DATE OF DEATH<br>Month <u>Dec</u> Day <u>10</u> Year <u>1967</u>   |   |
| 5. SEX<br><u>Female</u>   | 6. COLOR OR RACE<br><u>White</u>  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><u>Jan 26, 1875</u>                               |
| 9. AGE (In years last birthday)<br><u>92</u> yrs  |   | 10. IF UNDER 1 YEAR<br>Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min <u>  </u>  |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Housewife</u>   |   | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>at home</u>   |   |
| 11. BIRTH PLACE (County & State or foreign country)<br><u>Germany</u>   |   | 12. CITIZEN OF WHAT COUNTRY?<br><u>USA</u>  |   |
| 13. FATHER'S NAME<br><u>Isidore Oppenheimer</u>   |   | 14. MOTHER'S MAIDEN NAME<br><u>Lo Anna?</u>   |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) (If yes give war or dates of service)<br><u>no</u>   |   | 16. SOCIAL SECURITY NO.<br><u>26-46-0994</u>  |   |
| 17. INFORMANT<br><u>Mrs Henry Miller</u>  |   | Address<br><u>7703 Ardland Rd</u>   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute Coronary Vascular Accident</u><br>260X DUE TO (b) <u>Severe Myocardial Hypertension C.V.D</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <u>Cardiac insuff</u><br>INTERVAL BETWEEN ONSET AND DEATH <u>48 hrs</u><br><u>4 years</u> |   |   |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |   |   |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |   | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)  |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. <u>  </u> p.m. <u>19</u>  | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/><br>of work <input type="checkbox"/> of work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  | 20f. (City or town) (County) (State)                                  |
| 21. I certify that (I) (this hospital) attended the deceased from <u>Dec 1</u> , 19 <u>65</u> , to <u>Dec 10</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>Dec 9</u> , 19 <u>67</u> , and that death occurred at <u>5A</u> M, from causes and on the date stated above.  |   |   |   |
| 22a. SIGNATURE<br><u>Bernard Cohen</u>  |   | 22b. DATE SIGNED<br><u>12-11-67</u>   |   |
| 22c. PHYSICIAN'S NAME (Type)<br><u>BERNARD COHEN</u>  |   | 22d. ADDRESS<br><u>3501 ST PAUL STREET</u>  |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)   | 23b. DATE THEREOF<br><u>Dec 11/67</u>   | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Hai Sinai</u>  | 23d. LOCATION (City or Town) (County) (State)<br><u>Baltimore, Md</u> |
| 24. FUNERAL DIRECTOR<br><u>Sol Levinson &amp; Bros. 6010 Reisterstown Rd.</u>   |   | 25a. REC'D BY REGISTRAR<br>DATE <u>DEC 12 1967</u>  |   |
|   |   | 25b. REGISTRAR'S SIGNATURE<br><u>Charles Judge</u>  |   |





# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

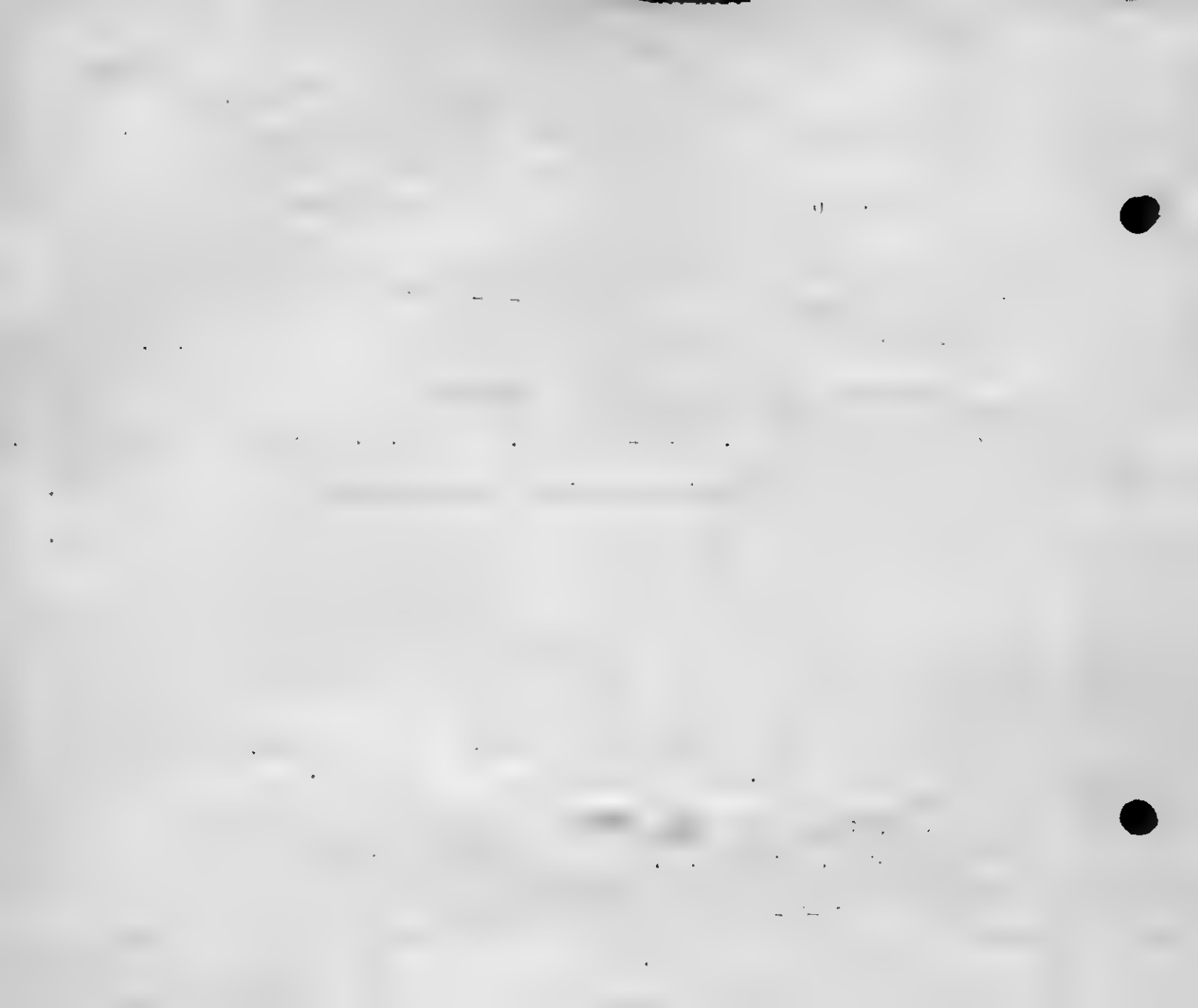
16668

16661

|  |  |   |  |
|--|--|---|--|
| <b>1. PLACE OF DEATH</b><br>a. COUNTY <b>Baltimore</b><br>b. CITY OR TOWN (if outside corporate limits write RURAL and give nearest town) <b>Halethorpe</b><br>c. LENGTH OF STAY IN 16 <b>50 ?</b><br>d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>5700 Second Avenue</b>                                     |  | <b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission)<br>a. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Halethorpe</b><br>b. STREET ADDRESS <b>5700 Second Avenue</b><br>c. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| <b>3. NAME OF DECEASED</b> (Type or print)<br><b>JOHN GEORGE SCHROEDER</b>   |  | <b>4. DATE OF DEATH</b><br>December 13, 1967  |  |
| <b>5. SEX</b><br>Male  | <b>6. COLOR OR RACE</b><br>White   | <b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>  | <b>8. DATE OF BIRTH</b><br>12-14-11 1879   |
| <b>9. AGE</b> (In years last birthday) <b>87</b> yrs.<br>IF UNDER 1 YEAR: Months _____ Days _____<br>IF UNDER 24 HRS.: Hours _____ Min. _____  |  | <b>10. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Post Office</b><br><b>11. BIRTHPLACE</b> (County & State, or foreign country) <b>Maryland</b><br><b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U. S. of America</b>   |  |
| <b>13. FATHER'S NAME</b><br>Not known George Schroeder   |  | <b>14. MOTHER'S MAIDEN NAME</b><br>Not known Luise Volland  |  |
| <b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <b>Yes</b><br>(If yes give war or dates of service) <b>Spanish &amp; Amer.</b>  |  | <b>16. SOCIAL SECURITY NO.</b> <b>220-44-5482</b><br><b>17. INFORMANT</b> <b>Mrs. Marion D. B. Schroeder - 5700 Second Ave.</b>   |  |
| <b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Chronic myocarditis with decompensation</b><br>DUE TO <b>Hypertension</b><br>Conditions, if any, which gave rise to immediate cause (b) _____<br>(a), stating the underlying cause last. (c) _____    |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>8 yrs.</b><br><b># yrs.</b>  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____  |  |   |  |
| <b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (If either, notify medical examiner) <input type="checkbox"/>   |  | <b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) _____   |  |
| <b>20c. TIME OF INJURY</b><br>Month, Day, Year<br>Hour a.m. _____ p.m. _____ 19____  | <b>20d. INJURY OCCURRED</b><br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) _____   | <b>20f. (City or town)</b> _____<br>(County) _____ (State) _____                     |
| <b>21. I certify that (I) (this hospital) attended the deceased from</b> <b>1955</b> <b>Dec. 11, 1967</b> <b>to</b> <b>Dec. 13, 1967</b> <b>that (I) (we) last saw the deceased alive on</b> <b>Dec. 11, 1967</b> <b>and that death occurred</b> <b>12:30 A.M.</b> <b>on</b> <b>Dec. 13, 1967</b> <b>the causes and on the date stated above</b> |  |   |  |
| <b>22a. SIGNATURE</b><br><b>Frederic V. Beitler M. D.</b>  |  | <b>22b. DATE SIGNED</b><br><b>12-13-67</b>  |  |
| <b>22c. PHYSICIAN'S NAME</b> (Type)<br><b>Frederic V. Beitler M. D.</b>  |  | <b>22d. ADDRESS</b><br><b>1014 Francis Avenue</b>   |  |
| <b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify)<br><b>Burial</b>  | <b>23b. DATE THEREOF</b><br><b>12-15-67</b>  | <b>23c. NAME OF CEMETERY OR CREMATORY</b><br><b>National Cemetery</b>   | <b>23d. LOCATION</b> (City, town or county) <b>Baltimore</b> (State) <b>Maryland</b> |
| <b>24. FUNERAL DIRECTOR'S SIGNATURE</b><br><b>HENRY SANDER &amp; SONS INC.</b><br><b>BALTIMORE MARYLAND</b>  |  | <b>25a. REC'D BY REGISTRAR</b> <b>DEC 19 1967</b><br><b>25b. REGISTRAR'S SIGNATURE</b> <i>Charles Judge</i>   |  |

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be retained by the hospital or attending physician.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20 M 1 66

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item #8 & 9 Filed 12/11/67 on

CERTIFICATE OF DEATH

|   |                           |  |   |
|---|---------------------------|--|---|
| 1666J   |                           | 16662  |   |
| 1 PLACE OF DEATH<br>a. COUNTY <u>Baltimore</u> MARYLAND   |                           | 2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)<br>a. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u>                    |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>   |                           | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>  |   |
| c. LENGTH OF STAY in 1b <u>64 yrs</u>   |                           | d. STREET ADDRESS <u>1329 Dillon Hgts Ave Zone 28</u>  |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Shangri-la Nursing Home</u>   |                           | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   |
| 3. NAME OF DECEASED (Type or print) <u>Marie Schroeder</u>  |                           | 4. DATE OF DEATH <u>12</u> Month <u>7</u> Day <u>19</u> Year <u>67</u>   |   |
| 5. SEX <u>F</u>   | 6. COLOR OR RACE <u>W</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. AGE (In years last birthday) <u>64</u> yrs |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>  |                           | 10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>  |   |
| 11. BIRTHPLACE (County & State or foreign country) <u>Md.</u>   |                           | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u>  |   |
| 13. FATHER'S NAME <u>Leo V. Schroeder</u>   |                           | 14. MOTHER'S MAIDEN NAME <u>unk</u>  |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>unk.</u>   |                           | 16. SOCIAL SECURITY NO. <u>unk.</u>  |   |
| 17. INFORMANT <u>Nursing Home Chart</u>   |                           | Address  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Vomiting &amp; Aspiration</u><br>DUE TO (b) <u>Chorea athetosis</u><br>DUE TO (c) <u>lost.</u>   |                           | INTERVAL BETWEEN ONSET AND DEATH <u>5 min.</u><br><u>5 yrs</u>   |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Marked General &amp; Mental Deterioration</u>   |                           | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)  |                           | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)  |   |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>   |                           | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>   |   |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |                           | 20f. (City or town) (County) (State)   |   |
| 21. I certify that (I) (this hospital) attended the deceased from <u>4/13</u> , 19 <u>67</u> , to <u>12/7</u> , 19 <u>67</u> that (I) (we) last saw the deceased alive on <u>12/7</u> , 19 <u>67</u> , and that death occurred at <u>2:30</u> PM, from causes and on the date stated above. |                           |  |   |
| 22a. SIGNATURE <u>W. E. Zick</u> M.D.   |                           | 22b. DATE SIGNED <u>12/7/67</u>  |   |
| 22c. PHYSICIAN'S NAME (Type) <u>W. E. Zick</u>  |                           | 22d. ADDRESS <u>4 VFW Lane, Ellicott City, Md.</u>   |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>   |                           | 23b. DATE THEREOF <u>12/11, 67</u>   |   |
| 23c. NAME OF CEMETERY OR CREMATORY <u>Woodlawn</u>  |                           | 23d. LOCATION (City or Town) (County) (State) <u>Baltimore Maryland</u>  |   |
| 24. FUNERAL DIRECTOR <u>J. T. Stansbury</u> ADDRESS <u>6411 Windsor Mill Rd.</u>  |                           | 25a. REC'D BY REGISTRAR <u>DEC 11 1967</u> 25b. REGISTRAR'S SIGNATURE <u>J. Charles Jones</u>  |   |



CERTIFICATE OF DEATH

16663

|   |                                  |   |   |
|---|----------------------------------|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Baltimore</b> <b>21236</b><br>MARYLAND  |                                  | 2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission)<br>a. STATE <b>Md.</b> <b>21236</b> b. COUNTY <b>1</b>                |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Overlea</b>  |                                  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Overlea</b>  |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>206 Sipple Ave.</b>  |                                  | d. STREET ADDRESS<br><b>206 Sipple Ave.</b>   |   |
| 3. NAME OF DECEASED (Type or print)<br>First Middle Last<br><b>GERTRUDE LAKE SCHULZE</b>  |                                  | 4. DATE OF DEATH<br>Month Day Year<br><b>December 3 19 67</b>   |   |
| 5. SEX<br><b>female</b>   | 6. COLOR OR RACE<br><b>white</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>June 4, 1895</b> |
| 9. AGE (In years last birthday) yrs.<br><b>72</b>   |                                  | 10. IF UNDER 1 YEAR<br>Months Days Hours Min.   |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housewife</b>   |                                  | 10b. K. ND. OF BUSINESS OR INDUSTRY<br><b>at home</b>   |   |
| 11. BIRTHPLACE (County & State, or foreign country)<br><b>Cambridge, Md.</b>  |                                  | 12. CITIZEN OF WHAT COUNTRY?  |   |
| 13. FATHER'S NAME<br><b>Hooper Smith</b>  |                                  | 14. MOTHER'S MAIDEN NAME<br><b>unknown</b>  |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><b>212-46-9649</b>   |                                  | 16. SOCIAL SECURITY NO.<br><b>212-46-9649</b>   |   |
| 17. INFORMANT<br><b>William E. Schulze, son, above</b>  |                                  | Address   |   |
| 18. CAUSE OF DEATH (Enter on one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY.<br>IMMEDIATE CAUSE (a) <b>Cervicocarcinoma of the Endometrium</b><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)<br>DUE TO (c)<br>INTERVAL BETWEEN ONSET AND DEATH<br><b>1 year</b> |                                  | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |                                  |   |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                                  | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)   |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m. <b>19</b>  |                                  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>   |   |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |                                  | 20f. (City or town) (County) (State)  |   |
| 21. I certify that (I) (this hospital) attended the deceased from <b>Aug</b> , 19 <b>66</b> , to <b>Dec</b> , 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>3 Dec</b> , 19 <b>67</b> , and that death occurred at <b>9:07</b> M, from causes and on the date stated above.   |                                  |   |   |
| 22a. SIGNATURE<br><b>George H. Miller</b>   |                                  | 22b. DATE SIGNED<br><b>12/4/67</b>  |   |
| 22c. PHYSICIAN'S NAME (Type)<br><b>Dr. George Miller</b>  |                                  | 22d. ADDRESS<br><b>6411 Belair Road</b>   |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |                                  | 23b. DATE THEREOF<br><b>12/7/67</b>   |   |
| 23c. NAME OF CEMETERY OR CREMATORY<br><b>Glen Haven Mem. Park</b>   |                                  | 23d. LOCATION (City or town) (County) (State)<br><b>Glen Burnie, Md.</b>  |   |
| 24. FUNERAL DIRECTOR<br><b>Schimunek Funeral Home, Inc.</b><br><b>3331 Brehms Lane</b>  |                                  | 25a. REC'D BY REGISTRAR<br><b>DEC 7 1967</b>  |   |
| 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>  |                                  |   |   |

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## CERTIFICATE OF DEATH

16664

|   |                                  |   |  |
|---|----------------------------------|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Baltimore county,</b> MARYLAND  |                                  | 2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)<br>a. STATE <b>Magothy Beach</b> b. COUNTY <b>Anne Arundel</b>         |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Arbustus</b>   |                                  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Pasadena, Maryland</b>   |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>Stanley Ankudas, MD. (Office)</b>  |                                  | d. STREET ADDRESS<br><b>Box #277</b>  |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Mr. Edgar</b> Middle <b>Leo</b> Last <b>Sears</b>   |                                  | 4. DATE OF DEATH<br>Month <b>12</b> Day <b>8</b> Year <b>1967</b>   |  |
| 5. SEX<br><b>male</b>   | 6. COLOR OR RACE<br><b>White</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>22 Sept. 1920</b> |
| 9. AGE (In years last birthday) <b>47</b> yrs   |                                  | 10. IF UNDER 1 YEAR<br>Months <b>12</b> Days <b>8</b> Hours <b>19</b> Min <b>67</b>   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Interior Decorator</b>  |                                  | 10b. KIND OF BUSINESS OR <b>Krownstein, Co. Inc.</b>  |  |
| 11. BIRTHPLACE (County & State or foreign country)<br><b>Lansdown, Maryland</b>   |                                  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.</b>   |  |
| 13. FATHER'S NAME<br><b>Jessie D. Sears</b>   |                                  | 14. MOTHER'S MAIDEN NAME<br><b>Mary V. Jackson</b>  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><b>yes WW II</b>   |                                  | 16. SOCIAL SECURITY NO.<br><b>218009-6350</b>   |  |
| 17. INFORMANT<br><b>L. Alberta Sears - Wife</b>   |                                  | Address   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Massive myocardial infarction</b><br>4201 DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) DUE TO<br>(c) DUE TO |                                  | INTERVAL BETWEEN ONSET AND DEATH  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |                                  |   |  |
| 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |                                  |   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)  |                                  | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. <b>19</b> p.m.  |                                  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>   |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |                                  | 20f. (City or town) (County) (State)  |  |
| 21. I certify that (I) (this hospital) attended the deceased from <b>12.8.1967</b> , to <b>12.8.1967</b> , that (I) (we) last saw the deceased alive on <b>12.8.1967</b> , and that death occurred at <b>3.12 P.M.</b> from causes and on the date stated above.  |                                  |   |  |
| 22a. SIGNATURE<br><b>Stanley Ankudas</b>  |                                  | 22b. DATE SIGNED<br><b>12/8/67</b>  |  |
| 22c. PHYSICIAN'S NAME (Type)<br><b>Stanley Ankudas, M.D.</b>  |                                  | 22d. ADDRESS<br><b>1101 Maiden Choice Lane #21229</b>   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>  |                                  | 23b. DATE THEREOF<br><b>12 Dec. 1967</b>  |  |
| 23c. NAME OF CEMETERY OR CREMATORY<br><b>Baltimore Nat'l. Cem.</b>  |                                  | 23d. LOCATION (City or town) (County) (State)<br><b>Baltimore, Maryland</b>   |  |
| 24. FUNERAL DIRECTOR<br><b>Singleton Funeral Home/Glen Burnie, Md.</b>  |                                  | 25a. REC'D BY REGISTRAR<br><b>DEC 11 1967</b>   |  |
| 25b. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>  |                                  |   |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

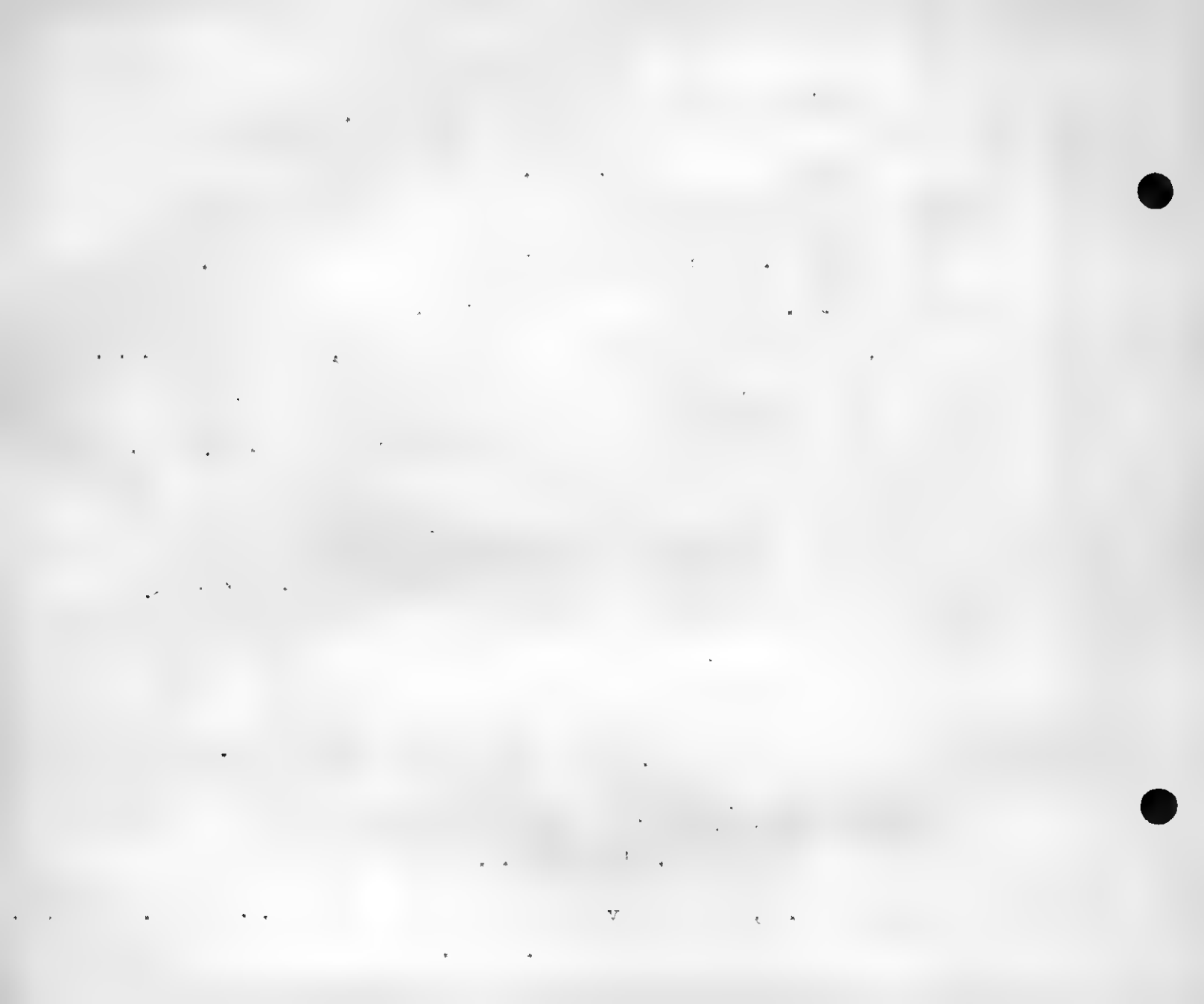




TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 12 hours after death.

16072  
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH 665

|   |                                 |  |  |
|---|---------------------------------|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Baltimore</b>   |                                 | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <b>Md.</b> b. COUNTY <b>Baltimore</b>                  |  |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)<br><b>Towson</b>   |                                 | c. LENGTH OF STAY IN 1b<br><b>20 yrs.</b>  |  |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)<br><b>Mission Helpers Of The Sacred Heart Convent</b>  |                                 | d. STREET ADDRESS<br><b>1001 West Joppa Road</b>   |  |
| 3. NAME OF DECEASED (Type or print)<br><b>Sister M. Immaculata (Katherine Shea)</b>   |                                 | 4. DATE OF DEATH<br>Month <b>Dec.</b> Day <b>31</b> Year <b>1967</b>   |  |
| 5. SEX<br><b>Female</b>   | 6. COLOR OR RACE<br><b>Cau.</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>March 5, 1877</b> |
| 9. AGE (In years last birthday)<br><b>90</b> yrs.   |                                 | IF UNDER 1 YEAR: Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min.   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Nun</b>   |                                 | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Convent</b>  |  |
| 11. BIRTHPLACE (County & State, or foreign country)<br><b>Fishersgraig, Ireland</b>   |                                 | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  |
| 13. FATHER'S NAME<br><b>Martin Shea</b>   |                                 | 14. MOTHER'S MAIDEN NAME<br><b>Catherine Byrne</b>   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)<br><b>no</b>  |                                 | 16. SOCIAL SECURITY NO.<br><b>none</b>   |  |
| 17. INFORMANT<br><b>Convent Records, 1001 W. Joppa Rd. Towson</b>   |                                 | Address  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Generalized Atherosclerosis</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>Coronary Artery Sclerosis</b><br>DUE TO (b) <b>Coronary Artery Sclerosis</b><br>DUE TO (c) <b>Coronary Artery Sclerosis</b><br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) |                                 |  |  |
| 19. INTERVAL BETWEEN ONSET AND DEATH  |                                 |  |  |
| 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |                                 |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                                 | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. <b>19</b> p.m.  |                                 | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>  |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |                                 | 20f. (City or town) (County) (State)   |  |
| 21. I certify that (I) (this hospital) attended the deceased from <b>1/7, 1960</b> to <b>12/31, 1967</b> , that (I) <b>last</b> saw the deceased alive on <b>12/31, 1967</b> , and that death occurred at <b>12/31, 1967</b> M, from the causes and on the date stated above.   |                                 |  |  |
| 22a. SIGNATURE<br><b>Charles F. O'Donnell, M.D.</b>   |                                 | 22b. DATE SIGNED<br><b>1/2/1968</b>  |  |
| 22c. PHYSICIAN'S NAME (Type)<br><b>Charles F. O'Donnell, M.D.</b>   |                                 | 22d. ADDRESS<br><b>7501 York Road</b>  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |                                 | 23b. DATE THEREOF<br><b>Jan. 3, 1968</b>   |  |
| 23c. NAME OF CEMETERY OR CREMATORY<br><b>Convent Cemetery</b>   |                                 | 23d. LOCATION (City, town or county) (State)<br><b>1001 W. Joppa Rd. Towson, Md.</b>   |  |
| 24. FUNERAL DIRECTOR<br><b>B. Vernon Gennery</b>  |                                 | 25a. REC'D BY REGISTRAR<br><b>JAN 3 1968</b>   |  |
| 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>  |                                 |  |  |



2

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH   |  |                                      |  |   |   |  |  |  |  |
|---|--|--------------------------------------|--|---|---|--|--|--|--|
| DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  |  |                                      |  |   |   |  |  |  |  |
| CERTIFICATE OF DEATH  |  |                                      |  |   |   |  |  |  |  |
| 1. PLACE OF DEATH<br>a. COUNTY <b>Baltimore</b><br>b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)<br>c. LENGTH OF STAY IN 1b<br>d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)<br><b>Hidgeway Manor Nursing Home</b>  |  |                                      |  |   | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <b>Maryland</b><br>b. COUNTY<br>c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)<br><b>Baltimore</b><br>d. STREET ADDRESS<br><b>121 Dennison Street</b><br>e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |  |  |
| 3. NAME OF DECEASED<br>(Type or print)<br>First <b>Juliana</b> Middle <b>Shuck</b> Last <b>Shuck</b>  |  |                                      |  |   | 4. DATE OF DEATH<br>Month <b>December</b> Day <b>17</b> Year <b>1967</b>  |  |  |  |  |
| 5. SEX<br><b>Female</b>   |  | 6. COLOR OR RACE<br><b>White</b>     |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 8. DATE OF BIRTH<br><b>Sept. 22, 1867</b>                              |  | 9. AGE (In years last birthday)<br><b>100</b> yrs. |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housewife</b>   |  | 10b. KIND OF BUSINESS OR INDUSTRY    |  | 11. BIRTHPLACE (County & State, or foreign country)<br><b>Maryland</b>  |   |  | 12. CITIZEN OF WHAT COUNTRY?   |  |  |
| 13. FATHER'S NAME<br><b>John Morissey</b>   |  |                                      |  |   | 14. MOTHER'S MAIDEN NAME<br><b>Amanda Clark</b>   |  |  |  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)<br><b>None</b>  |  | 16. SOCIAL SECURITY NO.              |  | 17. INFORMANT<br>Address<br><b>Mrs. Sarah Matessa 56 Mapledale Ave.</b>   |   |  |  |  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cerebral Vascular Hemorrhage</b><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b)<br>(c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br>19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |                                      |  |   |   |  |  |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>1 day</b> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |                                      |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)  |   |  |  |  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m. <b>19</b>  |  |                                      |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>   |   | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) |  | 20f. (City or town) (County) (State)               |  |
| 21. I certify that (I) (this hospital) attended the deceased from <b>1 Jan</b> , 19 <b>66</b> , to <b>17 Dec</b> , 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>16 Dec</b> , 19 <b>67</b> , and that death occurred at <b>2 P</b> M, from the causes and on the date stated above.  |  |                                      |  |   |   |  |  |  |  |
| 22a. SIGNATURE<br><b>William Goodman</b>  |  |                                      |  | M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>                        |   | 22b. DATE SIGNED<br><b>17 Dec 67</b>                                   |  |  |  |
| 22c. PHYSICIAN'S NAME (Type)<br><b>WILLIAM GOODMAN</b>  |  |                                      |  | 22d. ADDRESS<br><b>1334 Sulphur Spring Rd 2122</b>  |   |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |  | 23b. DATE THEREOF<br><b>12/21/67</b> |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>St. Patricks Cemetery</b>  |   |  | 23d. LOCATION (City, town or county) (State)<br><b>Cumberland, Md.</b> |  |  |
| 24. FUNERAL DIRECTOR<br><b>Wm F. Tichner &amp; Sons</b>   |  |                                      |  | ADDRESS<br><b>Baltimore, Md.</b>  |   | 25a. REC'D BY REGISTRAR<br><b>DEC 21 1967</b>                          |  | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b> |  |



16674

CERTIFICATE OF DEATH

10668

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

|   |  |   |   |   |  |   |  |
|---|--|---|---|---|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>BALTIMORE</b><br>MARYLAND   |  |   |   | 2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)<br>a. STATE <b>MARYLAND</b> b. COUNTY <b>BALTIMORE</b>                 |  |   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>FORT HOWARD</b>  |  |   | c. LENGTH OF STAY in 1b<br><b>60 DAYS</b> |   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>BALTIMORE</b> |   |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>VETERANS ADMINISTRATION HOSPITAL</b>   |  |   |   | d. STREET ADDRESS<br><b>10 CLOVER AVENUE</b>  |  |   |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>AUGUST</b> Middle <b>LOUIS</b> Last <b>SIMON</b>  |  |   |   | 4. DATE OF DEATH<br>Month <b>DECEMBER</b> Day <b>16</b> Year <b>19 67</b>   |  |   |  |
| 5. SEX<br><b>MALE</b>   |  | 6. COLOR OR RACE<br><b>WHITE</b>  |   | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><b>3/4/10</b>   |  |
| 9. AGE (In years last birthday)<br><b>57</b> yrs  |  | 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>LABORER</b> |   | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>STEEL</b>   |  | 11. BIRTHPLACE (County & State or foreign country)<br><b>BALTIMORE, MD</b>                        |  |
| 13. FATHER'S NAME<br><b>JOHN LOUIS SIMON</b>  |  |   |   | 14. MOTHER'S MAIDEN NAME<br><b>MARY ANN KOESTER</b>   |  |   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><b>YES WWII</b>  |  | 16. SOCIAL SECURITY NO<br><b>313 07 5673</b>  |   | 17. INFORMANT Address<br><b>CLIN. RECORDS, VA HOSPITAL, FT HOWARD, MD</b>   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CANCER OF PANCREAS</b><br>157X<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last }<br>DUE TO (b) _____<br>DUE TO (c) _____                                    |  |   |   |   |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>MONTHS</b>   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)  |  |   |   |   |  | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)                   |   |   |  |   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. _____ p.m. <b>19</b>  |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>     |   | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |  | 20f. (City or town) (County) (State)  |  |
| 21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>10/16/67</b> , 19____ to <b>12/16/67</b> 19____, that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>12/16/67</b> 19____, and that death occurred at <b>4:20AM</b> , from causes and on the date stated above. |  |   |   |   |  |   |  |
| 22a. SIGNATURE<br><i>George Dudas</i>   |  |   |   | M.D. ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>                          |  | 22b. DATE SIGNED<br><b>12 16 67</b>   |  |
| 22c. PHYSICIAN'S NAME (Type)<br><b>GEORGE DUDAS, MD</b>   |  |   |   | 22d. ADDRESS<br><b>VA HOSPITAL, FORT HOWARD, MARYLAND</b>   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |  | 23b. DATE THEREOF<br><b>12- 20-1967</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Zion Luth. Church Cemetery</b>   |  | 23d. LOCATION (City or Town) (County) (State)<br><b>Baltimore, Maryland</b>                       |  |
| 24. FUNERAL DIRECTOR<br><b>Lassahn Funeral Home</b>   |  |   |   | 25a. REC'D BY REGISTRAR<br><b>7401 Belair Rd. Baltimore, Md. 21236</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><i>Charles Judge</i>  |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 4 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

16675

16669

|  |   |  |   |
|--|---|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Baltimore</u> MARYLAND   |   | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)<br>a. STATE <u>Md.</u> b. COUNTY <u>-</u>                          |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Towson</u>  |   | c. LENGTH OF STAY IN TB  |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><u>Chesapeake Manor N. H.</u>  |   | d. STREET ADDRESS<br><u>116 W. University Pkwy.</u>  |   |
| 3. NAME OF DECEASED<br>(Type or print)<br>First <u>Lelia</u> Middle <u>I</u> Last <u>Sinclair</u>  |   | 4. DATE OF DEATH<br>Month <u>Dec.</u> Day <u>16</u> Year <u>1967</u>   |   |
| 5. SEX <u>F</u>  | 6. COLOR OR RACE <u>W</u>   | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><u>1-8-1874</u>                                   |
| 9. AGE (In years last birthday)<br><u>93</u> yrs.  |   | 10. IF UNDER 1 YEAR<br>Months <u>-</u> Days <u>-</u> Hours <u>-</u> Min. <u>-</u>  |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>None</u>   |   | 10b. KIND OF BUSINESS OR INDUSTRY  |   |
| 11. BIRTHPLACE (County & State or foreign country)<br><u>Baltimore, Md.</u>  |   | 12. CITIZEN OF WHAT COUNTRY?<br><u>USA</u>   |   |
| 13. FATHER'S NAME<br><u>Arthur Sinclair</u>  |   | 14. MOTHER'S MAIDEN NAME<br><u>Drusilla Willitt</u>  |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><u>No</u>   |   | 16. SOCIAL SECURITY NO<br><u>--</u>  |   |
| 17. INFORMANT<br><u>Talbot Sinclair</u>  |   | Address<br><u>Hyattsville, Md.</u>   |   |
| 18. CAUSE OF DEATH (Enter any one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>ARTERIO-SCLEROTIC HEART DISEASE</u><br>DUE TO (b) <u>4200</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO (c) |   | INTERVAL BETWEEN ONSET AND DEATH<br><u>2 DAYS</u>  |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)   |   | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |   | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)   |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. <u>19</u> p.m.   | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   | 20f. (City or town) (County) (State)                                  |
| 21. I certify that (I) (his hospital) attended the deceased from <u>EMERGENCY</u> , 1964, to <u>DEC 16</u> , 1967, that (I) (we) last saw the deceased alive on <u>DEC 15</u> , 1967, and that death occurred at <u>3:30</u> A.M. from causes and on the date stated above.                                      |   |  |   |
| 22a. SIGNATURE<br><u>John M. Scott</u>   |   | 22b. DATE SIGNED<br><u>DEC 16, 1967</u>  |   |
| 22c. PHYSICIAN'S NAME (Type)<br><u>JOHN M. SCOTT</u>   |   | 22d. ADDRESS<br><u>600 W. BELVIDERE AVE., BALTIMORE 2120</u>   |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial</u>   | 23b. DATE THEREOF<br><u>12-18-67</u>  | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Greenmount</u>  | 23d. LOCATION (City or Town) (County) (State)<br><u>Baltimore Md.</u> |
| 24. FUNERAL DIRECTOR<br><u>H.W. Jenkins &amp; Sons Co. 4905 York Rd., Balto., Md.</u>  |   | 25a. REC'D BY REGISTRAR<br><u>DEC 19 1967</u>  | 25b. REGISTRAR'S SIGNATURE<br><u>William J. Judge</u>                 |





16676

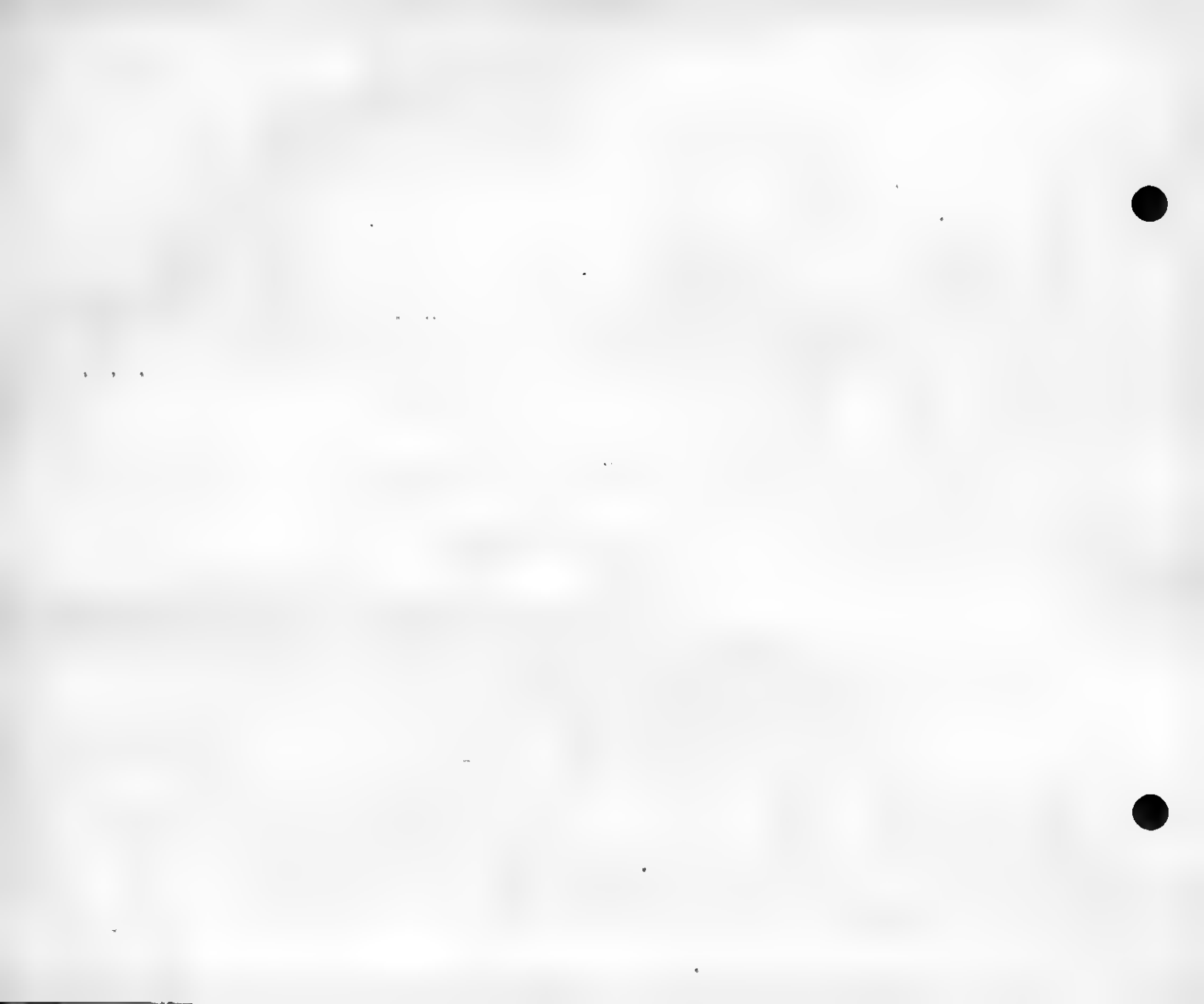
## CERTIFICATE OF DEATH

16670

|  |   |  |   |
|--|---|--|---|
| 1 PLACE OF DEATH<br>a. COUNTY <b>Baltimore</b> MARYLAND  |   | 2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>15-10-10</b>                 |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Towson</b>  |   | c. LENGTH OF STAY IN 1b<br><b>1005 Sayward Avenue</b>  |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>St. Joseph Hospital</b>   |   | d. STREET ADDRESS<br><b>Baltimore, Maryland 21234</b>  |   |
| 3 NAME OF DECEASED<br>(Type or print)<br>First <b>ELIZABETH</b> Middle <b>M.</b> Last <b>SMALLWOOD</b>   |   | 4 DATE OF DEATH<br>Month <b>December</b> Day <b>23</b> Year <b>19 67</b>   |   |
| 5. SEX<br><b>Female</b>  | 6 COLOR OR RACE<br><b>White</b>   | 7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8 DATE OF BIRTH<br><b>1-29-82</b>   |
| 9 AGE (In years last birthday)<br><b>85</b> yrs  |   | IF UNDER 1 YEAR<br>Months <b>1</b> Days <b>1</b> Hours <b>1</b> Min.   |   |
| 10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housewife</b>   |   | 10b. KIND OF BUSINESS OR INDUSTRY  |   |
| 11 BIRTHPLACE (County & State or foreign country)<br><b>West Virginia</b>  |   | 12 CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |   |
| 13 FATHER'S NAME<br><b>John E. Mantz</b>   |   | 14 MOTHER'S MAIDEN NAME<br><b>Margaret</b>   |   |
| 15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><b>No</b>  |   | 16 SOCIAL SECURITY NO<br><b>213-18-7601</b>  |   |
| 17 INFORMANT<br><b>Nephew - Byron Barton</b>   |   | Address<br><b>same</b>   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Probable cardiac failure</b><br>DUE TO (b) <b>Mitral insufficiency</b><br>DUE TO (c) <b></b>   |   |  | INTERVAL BETWEEN ONSET AND DEATH  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)<br><b>Marked emaciation</b>   |   |  | 19 WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |   | 20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part or Part I of item 18)   |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. <b>19</b> p.m. <b>19</b>   | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> at work <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> | 20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  | 20f. (City or town) (County) (State)  |
| 21. I certify that <del>he</del> (this hospital) attended the deceased from <b>12-23-</b> , 1967, to <b>12-23</b> , 1967, that <del>he</del> (we) last saw the deceased alive on <b>12-23</b> , 1967, and that death occurred at <b>12-23</b> M, from causes and on the date stated above. |   |  |   |
| 22a SIGNATURE<br><b>Samuel Lee</b>   |   | 22b DATE SIGNED<br><b>12/24/67</b>   |   |
| 22c. PHYSICIAN'S NAME (Type)<br><b>Samuel Lee, M.D.</b>  |   | 22d. ADDRESS<br><b>7620 York Rd.</b>   |   |
| 23a BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  | 23b. DATE THEREOF<br><b>12/23/67</b>  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Druid Ridge</b>   | 23d. LOCATION (City or Town) (County) (State)<br><b>Baltimore Maryland</b>            |
| 24. FUNERAL DIRECTOR<br><b>Leonard J. Ruck Inc. 5305 Harford Rd</b>  |   | 25a REC'D BY REGISTRAR<br><b>DATE DEC 27 1967</b>  |   |
|  |   | 25b REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>  |   |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 should be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AIS (4)  
15M 7-62

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

|   |  |   |  |
|---|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Baltimore</u><br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Randallstown</u><br>c. LENGTH OF STAY IN 1b <u>3 weeks</u><br>d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Baltimore Co. General Hospital</u> |  | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)<br>a. STATE <u>Maryland</u><br>b. COUNTY <u>Baltimore</u><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Randallstown</u><br>d. STREET ADDRESS <u>3416 Chapman Rd.</u><br>e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |
| 3. NAME OF DECEASED (Type or print)<br>First <u>David</u> Middle <u>E</u> Last <u>Smith</u><br>DATE OF DEATH <u>Dec. 12, 1967</u>   |  | 9. AGE (In years last birthday) <u>84</u> yrs.<br>IF UNDER 1 YEAR Months Days<br>IF UNDER 24 HRS. Hours Min.  |  |
| 5. SEX <u>M</u><br>6. COLOR OR RACE <u>W</u><br>7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>   |  | 8. DATE OF BIRTH <u>9-7-83</u><br>9. BIRTHPLACE (County & State, or foreign country) <u>ARKANSAS</u><br>12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER</u><br>13. FATHER'S NAME <u>Unk.</u>  |  | 10b. KIND OF BUSINESS OR INDUSTRY <u>FARMING</u><br>14. MOTHER'S MAIDEN NAME <u>Unk.</u>  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u><br>16. SOCIAL SECURITY NO. <u>431-68-8661</u><br>17. INFORMANT <u>Mrs Irene Holcomb - Randallstown, Md</u><br>Address   |  | 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>POSS. Pulm. Infarction</u><br>5411 DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO <u>Post operative (Bleeding Dysrhythmia ulcer perforation Spontaneous color</u><br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>?</u><br>INTERVAL BETWEEN ONSET AND DEATH <u>?</u> |  |
| 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/><br>20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  | 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m. <u>19</u><br>20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/><br>20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)<br>20f. (City or town) (County) (State)  |  |
| 21. I certify that (I) (this hospital) attended the deceased from <u>1-9-1967</u> to <u>12-12-1967</u> , that (I) (we) last saw the deceased alive on <u>12-12-1967</u> , and that death occurred at <u>2:25</u> P.M. from the causes and on the date stated above.   |  |   |  |
| 22a. SIGNATURE <u>Andberto B. Flores MD</u><br>22c. PHYSICIAN'S NAME (Type) <u>ANDBERTO P. FLORES</u><br>22d. ADDRESS <u>3502 W. Rogers Ave.</u>  |  | 22b. DATE SIGNED <u>12-12-67</u><br>ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u><br>23b. DATE THEREOF <u>12-16-67</u><br>23c. NAME OF CEMETERY OR CREMATORY <u>Bentonville Cemetery</u><br>23d. LOCATION (City, town or county) (State) <u>Bentonville, ARK.</u>   |  | 24. FUNERAL DIRECTOR'S SIGNATURE <u>Ruth A. Haight</u> ADDRESS <u>Hypherville, Md.</u><br>25a. REC'D BY REGISTRAR <u>DEC 15 1967</u><br>25b. REGISTRAR'S SIGNATURE <u>Francis J. J...</u>   |  |

MAINE STATE DEPARTMENT

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

| MARYLAND STATE DEPARTMENT OF HEALTH  |                              |   |  |  |  |                                |   |                  |   |   |
|--|------------------------------|---|--|--|--|--------------------------------|---|------------------|---|---|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |                              |   |  |  |  |                                |   |                  |   |   |
| CERTIFICATE OF DEATH   |                              |   |  |  |  |                                |   |                  |   |   |
| 16672  |                              |   |  |  |  |                                |   |                  |   |   |
| 1. PLACE OF DEATH<br>a. COUNTY<br><b>Baltimore</b><br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Mount Wilson</b>  |                              |   |  |  | 2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)<br>a. STATE<br><b>Md.</b><br>b. COUNTY<br><b>Carroll</b><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Hampstead Manchester</b> |                                |   |                  |   |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>Mount Wilson State Hospital</b>   |                              |   |  |  | d. STREET ADDRESS<br><b>107 N. Main St.</b>  |                                |   |                  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |
| 3. NAME OF DECEASED<br>(Type or print)<br>First Middle Last<br><b>EMORY HOLLICE SMITH</b>  |                              |   |  |  | 4. DATE OF DEATH<br>Month Day Year<br><b>12 / 14 / 1967</b>  |                                |   |                  |   |   |
| 5. SEX<br><b>M</b>   | 6. COLOR OR RACE<br><b>W</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>10/18/1896</b>  |  | 9. AGE (In years last birthday)<br><b>71</b> yrs   | IF UNDER 1 YEAR<br>Months Days | IF UNDER 24 HRS<br>Hours Min  |                  |   |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>store clerk</b>  |                              |   | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Dept. Store</b>  |  | 11. BIRTHPLACE (County & State, or foreign country)<br><b>Hampstead, Md.</b>   |                                | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                           |                  |   |   |
| 13. FATHER'S NAME<br><b>John Smith.</b>  |                              |   |  |  | 14. MOTHER'S MAIDEN NAME<br><b>Iola Snider</b>   |                                |   |                  |   |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) (If yes give war or dates of service)   |                              |   | 16. SOCIAL SECURITY NO.<br><b>220-07-9742</b>  |  | 17. INFORMANT<br>Address<br><b>Records, Mount Wilson State Hosp.</b>   |                                |   |                  |   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>52% due to</b><br>DUE TO <b>Cor pulmonale</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>chronic obstructive pulmonary disease.</b><br>DUE TO (c) |                              |   |  |  |  |                                |   |                  |   | INTERVAL BETWEEN ONSET AND DEATH  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |                              |   |  |  |  |                                |   |                  |   | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                              |   | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)                  |  |  |                                |   |                  |   |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m. <b>19</b>   |                              |   | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Not While <input type="checkbox"/><br>at work at work |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |                                | 20f. (City or town) (County) (State)                                    |                  |   |   |
| 21. I certify that (I) (this hospital) attended the deceased from <b>10/25/1967</b> to <b>12/14/1967</b> that (I) (we) last saw the deceased alive on <b>12/14/1967</b> , and that death occurred at <b>11:55 P.M.</b> from causes and on the date stated above.   |                              |   |  |  |  |                                |   |                  |   |   |
| 22a. SIGNATURE<br><b>W. Newcomer</b>   |                              |   |  |  | M.D. ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>  |                                |   | 22b. DATE SIGNED |   |   |
| 22c. PHYSICIAN'S NAME (Type or print)<br><b>Wm. Newcomer, M.D., Superintendent</b>   |                              |   |  |  | 22d. ADDRESS<br><b>Mount Wilson, Maryland</b>  |                                |   |                  |   |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |                              | 23b. DATE THEREOF<br><b>Dec. 17, 1967</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Manchester Cemetery</b> |  |                                | 23d. LOCATION (City or town) (County) (State)<br><b>Manchester, Md.</b> |                  |   |   |
| 24. FUNERAL DIRECTOR<br><b>Tipton - Eline Funeral Home Hampstead, Md.</b>  |                              |   |  |  | 25a. REC'D BY REGISTRAR<br>DATE<br><b>DEC 18 1967</b>  |                                | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>                      |                  |   |   |



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

16679

16673

|  |  |  |  |
|--|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY<br><b>Baltimore</b> MARYLAND  |  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE<br><b>Maryland</b> b. COUNTY<br><b>Baltimore</b> |  |
| b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town)<br><b>Garrison</b>   |  | c. LENGTH OF STAY IN IB<br><b>10 weeks</b>   |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>Foxleigh Nursing Home</b>   |  | e. STREET ADDRESS<br><b>Berrymans Lane</b>   |  |
| 3. NAME OF DECEASED<br>(Type or print)<br><b>John William Smith</b>  |  | 4. DATE OF DEATH<br>Month <b>Dec.</b> Day <b>16</b> Year <b>1967</b>   |  |
| 5. SEX<br><b>Male</b>  | 6. COLOR OR RACE<br><b>White</b>   | 7. MARRIED<br><input type="checkbox"/> NEVER MARRIED<br><input checked="" type="checkbox"/> WIDOWED<br><input type="checkbox"/> DIVORCED           | 8. DATE OF BIRTH<br><b>April 25, 1884</b> 85 yrs                                 |
| 9. AGE (in years at birthday)<br><b>85</b>   |  | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Dye worker</b>                                    | 11. BIRTHPLACE (County & State, or foreign country)<br><b>Baltimore Co., Md.</b> |
| 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 13. FATHER'S NAME<br><b>George Albert Smith</b>  |  |
| 14. MOTHER'S MAIDEN NAME<br><b>Ella Lee</b>  |  | 15. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) <b>No</b>   |  |
| 16. SOCIAL SECURITY NO.<br><b>216-10-6743</b>  |  | 17. INFORMANT<br><b>Mrs. Ruth Redifer</b>  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cerebral Vascular Accident</b><br>DUE TO (b) <b>Arteriosclerosis - generalized</b><br>DUE TO (c) <b>years</b>                               |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>1 month</b>   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |  |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m. <b>19</b>   | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Not While <input type="checkbox"/><br>at work at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   | 20f. (City or town) (County) (State)   |
| 21. I certify that (I) (this hospital) attended the deceased from <b>August, 1967</b> to <b>December 16, 1967</b> that (I) (we) last saw the deceased alive on <b>December 15, 1967</b> , and that death occurred at <b>6:00 AM</b> , from causes and on the date stated above |  |  |  |
| 22a. SIGNATURE<br><b>Clarence E. McWilliams</b> M.D.   |  | 22b. DATE SIGNED<br><b>12-17-67</b>  |  |
| 22c. PHYSICIAN'S NAME (Type)<br><b>Clarence E. McWilliams M.D.</b>   |  | 22d. ADDRESS<br><b>11909 Reisterstown Rd. Reisterstown, Md.</b>  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   | 23b. DATE THEREOF<br><b>Dec. 19, 1967</b>  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Saters Baptist Cem.</b>   | 23d. LOCATION (City or town) (County) (State)<br><b>Baltimore Co., Md.</b>       |
| 24. FUNERAL DIRECTOR<br><b>H. J. Schhardt</b>  |  | 25a. REC'D BY REGISTRAR<br><b>Owings Mills, Md.</b>  |  |
| 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>   |  | DATE<br><b>DEC 20 1967</b>   |  |





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health or to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

16680

16674

|  |                               |  |  |  |  |   |   |
|--|-------------------------------|--|--|--|--|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Baltimore</u> MARYLAND   |                               |  |  | 2. USUAL RESIDENCE (Where deceased lived, if institut on. Residence before admission)<br>a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> |  |   |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Catonsville</u>   |                               | c. LENGTH OF STAY IN IB<br><u>10 da.</u>   |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Baltimore 21214</u>                                   |  |   |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><u>Summit Nursing Home</u>   |                               |  |  | d. STREET ADDRESS<br><u>3108 Northern Parkway</u>  |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |
| 3. NAME OF DECEASED (Type or print)<br>First <u>Mrs. Julia</u> Middle <u>A</u> Last <u>Smith</u>   |                               |  |  | 4. DATE OF DEATH<br>Month <u>12</u> Day <u>18</u> Year <u>1967</u>   |  |   |   |
| 5. SEX<br><u>F</u>   | 6. COLOR OR RACE<br><u>W.</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>    | 8. DATE OF BIRTH<br><u>Feb 25 1890</u>   | 9. AGE (In years last birthday)<br><u>77</u> yrs.  | IF UNDER 1 YEAR<br>Months <u>  </u> Days <u>  </u> | IF UNDER 24 HRS<br>Hours <u>  </u> Min <u>  </u>  |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Housewife</u>  |                               | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>Home</u>   |  | 11. BIRTHPLACE (County & State, or foreign country)<br><u>Virginia</u>   |  | 12. CITIZEN OF WHAT COUNTRY?<br><u>USA</u>  |   |
| 13. FATHER'S NAME<br><u>John Henry Kexer</u>   |                               |  |  | 14. MOTHER'S MAIDEN NAME<br><u>Clara Puckett</u>   |  |   |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><u>No</u>   |                               | 16. SOCIAL SECURITY NO<br><u>212 28 8473A</u>  |  | 17. INFORMANT<br><u>Mrs. Robin Romer (Daughter)</u> Address <u>222 Nicholson Ave. Ferndale, Md. Bowie</u>                                    |  |   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY.<br>IMMEDIATE CAUSE (a) <u>1) Arteriosclerosis for Cerebrovascular disease</u><br>DUE TO <u>disease</u><br>(b) <u>2) Cerebrovascular accident</u><br>DUE TO <u>Congestive heart failure</u><br>(c) <u>3) Diabetes Mellitus</u> |                               |  |  |  |  |   | INTERVAL BETWEEN ONSET AND DEATH<br><u>  </u>   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |                               |  |  |  |  |   | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                               |  | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) |  |  |   |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour <u>  </u> a.m. <u>  </u> p.m. <u>  </u> 19 <u>  </u>  |                               | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Not While <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)                     |  | 20f. (City or town) (County) (State)               |   |   |
| 21. I certify that (I) (this hospital) attended the deceased from <u>12/18</u> , 19 <u>67</u> , to <u>12/18</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>12/18</u> , 19 <u>67</u> , and that death occurred at <u>3:45 p.m.</u> from causes and on the date stated above.                                      |                               |  |  |  |  |   |   |
| 22a. SIGNATURE<br><u>Edmund Kasaitis, M.D.</u>   |                               |  |  | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>              |  | 22b. DATE SIGNED<br><u>12/18/67</u>   |   |
| 22c. PHYSICIAN'S NAME (Type)<br><u>EDMUND KASAITIS, M.D.</u>   |                               |  |  | 22d. ADDRESS<br><u>1801 FREDRICK ROAD # 28</u>   |  |   |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)  |                               | 23b. DATE THEREOF<br><u>12/21/67</u>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Gardens of Faith</u>  |  | 23d. LOCATION (City or Town) (County) (State)<br><u>Baltimore Co., Md.</u>                        |   |
| 24. FUNERAL DIRECTOR<br><u>James E. Bruzdinski</u>   |                               |  |  | 25a. REC'D BY REGISTRAR<br>DATE <u>DEC 26 1967</u>   |  | 25b. REGISTRAR'S SIGNATURE<br><u>Charles Judge</u>  |   |



# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 10-100-1. 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (S)  
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

16681

16675

|  |                             |  |  |  |  |  |  |
|--|-----------------------------|--|--|--|--|--|--|
| 1 PLACE OF DEATH<br>a COUNTY <u>Baltimore</u> MARYLAND   |                             |  |  | 2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission)<br>a STATE <u>Maryland</u> b COUNTY <u>Balto.</u> |  |  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Catonsville</u>   |                             |  | c LENGTH OF STAY IN 1b   |  |  | c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Catonsville, Md. 21228</u> |  |
| d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><u>5913 Leewood Ave.</u>  |                             |  |  | d STREET ADDRESS<br><u>5913 Leewood Ave.</u>   |  |  | e IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 3 NAME OF DECEASED<br>(Type or print) <u>Marshall (NMN) Smith</u>  |                             |  |  | 4 DATE OF DEATH<br>Month <u>Dec.</u> Day <u>3</u> Year <u>1967</u>   |  |  |  |
| 5 SEX<br><u>M</u>  | 6 COLOR OR RACE<br><u>C</u> | 7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8 DATE OF BIRTH<br><u>8/17/05</u>  | 9 AGE (In years last birthday)<br><u>62</u> yrs  | IF UNDER 1 YEAR<br>Months <u></u> Days <u></u>                                   |  | IF UNDER 24 HRS<br>Hours <u></u> Min. <u></u>  |
| 10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>CUSTODIAN</u>   |                             |  | 10b KIND OF BUSINESS OR INDUSTRY<br><u>Howard Co. School Board</u>                                       |  | 11 BIRTHPLACE (State or foreign country)<br><u>Virginia</u>                      |  | 12 CITIZEN OF WHAT COUNTRY?<br><u>U.S. A.</u>  |
| 13 FATHER'S NAME<br><u>Robert Smith</u>  |                             |  |  | 14 MOTHER'S MAIDEN NAME<br><u>Magnolia Thomas</u>  |  |  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) (If yes give war or dates of service)   |                             |  | 16. SOCIAL SECURITY NO   |  | 17. INFORMANT<br>Address   |  |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1 DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <u>Cardio-vascular Disease</u><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <u>143X</u><br>(c) <u></u>  |                             |  |  |  |  |  | INTERVAL BETWEEN ONSET AND DEATH<br><u>Sudden</u>  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)<br><u>Hypertension</u>  |                             |  |  |  |  |  | 19 WAS A Topsy PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a EXTERNAL CAUSE WAS<br>PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/><br>CAUSE OF DEATH.   |                             |  | 20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of item 18.)                |  |  |  |  |
| 20c TIME OF INJURY Month, Day, Year<br>Hour a.m. <u>19</u> p.m. <u></u>  |                             |  | 20d INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> |  | 20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)            |  | 20f (City or town) (County) (State)  |
| 21 I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> |                             |  |  |  |  |  | 22. DATE SIGNED<br><u>12/4/67</u>  |
| ACTUAL SIGNATURE <u>James N. Frederick</u> M.D.  |                             |  | CHIEF MEDICAL EXAMINER <input type="checkbox"/>  |  | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>                              |  |  |
| EXAMINER'S NAME (Type) <u>James N. Frederick</u>   |                             |  | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>  |  | Address (Street, city, town, or county) <u>1311 Francis Ave Balto. Md. 21227</u> |  |  |
| 23a BURIAL, CREMATION, REMOVAL (Specify)<br><u>BURIAL</u>  |                             | 23b DATE THEREOF<br><u>Dec. 6 1967</u>   |  | 23c NAME OF CEMETERY OR CREMATORY<br><u>West Star Cemetery</u>   |  | 23d LOCATION (City or Town) (County) (State)<br><u>Catonsville, Balt. Md.</u>                                    |  |
| 24 FUNERAL DIRECTOR<br><u>Robert L. Snowden</u>  |                             |  | ADDRESS<br><u>Rockville, Md.</u>   |  | 25a REC'D BY REG STRAR<br><u>DEC 8 1967</u>                                      |  | 25b REGISTRAR'S SIGNATURE<br><u>Charles Judge</u>  |



16682

## CERTIFICATE OF DEATH

16676

|  |   |   |  |
|--|---|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Baltimore</b><br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Parkville</b><br>c. LENGTH OF STAY IN 1b<br>d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>7916 Oak Dale Avenue</b>  |   | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <b>Maryland</b><br>b. COUNTY<br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Parkville</b><br>d. STREET ADDRESS <b>7916 Oakdale Ave.</b><br>e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>MARY</b> Middle <b>E.</b> Last <b>SMITH</b>  |   | 4. DATE OF DEATH<br>Month <b>December</b> Day <b>5</b> Year <b>1967</b>   |  |
| 5. SEX <b>Female</b>   | 6. COLOR OR RACE <b>White</b>   | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>   | 8. DATE OF BIRTH <b>12-2-90</b>  |
| 9. AGE (In years last birthday) <b>77</b> yrs  |   | 10. IF UNDER 1 YEAR<br>Months Days Hours Min.   | 11. IF UNDER 24 HRS.<br>Hours Min.   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>   |   | 10b. KIND OF BUSINESS OR INDUSTRY   |  |
| 11. BIRTHPLACE (County & State, or foreign country) <b>Balto., Md.</b>   |   | 12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>  |  |
| 13. FATHER'S NAME <b>Jacob Buettner</b>  |   | 14. MOTHER'S MAIDEN NAME <b>Maedelene Fink</b>  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>  |   | 16. SOCIAL SECURITY NO <b>214-03-2842D</b>  |  |
| 17. INFORMANT Address <b>Madeline Andrew, 7916 Oakdale Ave.</b>  |   |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cerebral Vascular Accident</b><br><b>4221</b> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. }<br>(b) <b>Arteriosclerotic C-V Disease</b> DUE TO<br>(c) <b>Diabetes Mellitus</b> |   |   | INTERVAL BETWEEN ONSET AND DEATH<br><b>5 years</b>   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br><b>Diabetes Mellitus</b>  |   |   | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |   | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m. <b>19</b>   | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  | 20f. (City or town) (County) (State)   |
| 21. I certify that (I) (this hospital) attended the deceased from <b>Apr 2</b> , 1960, to <b>Dec 5</b> , 1967, that (I) (we) last saw the deceased alive on <b>Dec 4</b> , 1967, and that death occurred at <b>8 A</b> M, from causes and on the date stated above.  |   |   |  |
| 22a. SIGNATURE <b>George Sawyer</b>  |   | 22b. DATE SIGNED <b>12/5/67</b>   |  |
| 22c. PHYSICIAN'S NAME (Type) <b>GEORGE SAWYER</b>  |   | 22d. ADDRESS <b>4808 HARFORD RD.</b>  |  |
| 23a. BURIAL, CREMATION, REMOVAL (specify) <b>Burial</b>  | 23b. DATE THEREOF <b>12-9-67</b>  | 23c. NAME OF CEMETERY OR CREMATORY <b>Holy Redeemer</b>   | 23d. LOCATION (City or Town) (County) (State) <b>Balto., Md.</b>                               |
| 24. FUNERAL DIRECTOR ADDRESS <b>Leonard J. Ruck, Inc. Balto. Md. 21214</b>   |   | 25a. REC'D BY REGISTRAR DATE <b>DEC 6 1967</b>  | 25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

00-110000



# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## CERTIFICATE OF DEATH

16683

16677

|  |   |  |   |
|--|---|--|---|
| 1 PLACE OF DEATH<br>a. COUNTY<br><b>Baltimore</b><br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Towson</b>   |   | 2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE<br><b>Maryland</b><br>b. COUNTY<br><b>Baltimore</b><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Baltimore 21221</b> |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>ST. JOSEPH HOSPITAL</b>   |   | e. STREET ADDRESS<br><b>935 Woodlyn Rd.</b><br>f. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   |
| 3. NAME OF DECEASED (Type or print)<br>First Middle Last<br><b>Tonia Rene SMITH</b>  |   | 4. DATE OF DEATH<br>Month Day Year<br><b>December 5, 1967</b>  |   |
| 5. SEX<br><b>Female</b>  | 6. COLOR OR RACE<br><b>White</b>  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>  | 8. DATE OF BIRTH<br><b>November 14, 1967</b>  |
| 9. AGE (In years last birthday) yrs.<br><b>21</b>  |   | 10. IF UNDER 1 YEAR<br>Months Days Hours Min.<br><b>21</b>   |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired)<br><b>None</b>  |   | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>--</b>   |   |
| 11. BIRTHPLACE (County & State, or foreign country)<br><b>Baltimore, Maryland</b>  |   | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |   |
| 13. FATHER'S NAME<br><b>Arthur Lee Smith</b>   |   | 14. MOTHER'S MAIDEN NAME<br><b>Arlene Shanaberger</b>  |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><b>NO</b>   |   | 16. SOCIAL SECURITY NO<br><b>NONE</b>  |   |
| 17. INFORMANT<br><b>Arthur L. Smith</b>  |   | Address<br><b>Same</b>   |   |
| 18. CAUSE OF DEATH (Enter any one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Hemoperitoneum</b><br>DUE TO<br><b>18X</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>laceration of spleen.</b><br>DUE TO<br>(c)                                  |   |  | INTERVAL BETWEEN ONSET AND DEATH  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)   |   |  | 19. WAS AUTOPSY PERFORMED?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m.<br><b>19</b>  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   | 20f. (City or town) (County) (State)  |
| 21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>11/14/</b> , 19 <b>67</b> , to <b>12/5/</b> , 19 <b>67</b> , that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on <b>12/5/</b> , 19 <b>67</b> , and that death occurred at <b>1:30</b> M., from causes on and on the date stated above. |   |  |   |
| 22a. SIGNATURE<br><b>Samuel J. Misank</b>  |   | 22b. DATE SIGNED<br><b>12/5/67</b>   |   |
| 22c. PHYSICIAN'S NAME (Type)<br><b>Lawrence F. Misank, M.D.</b>  |   | 22d. ADDRESS<br><b>7620 York Rd., Towson, Md. 21204</b>  |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   | 23b. DATE THEREOF<br><b>12/7/67</b>   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Gardens of Faith Cemetery</b>   | 23d. LOCATION (City or Town) (County) (State)<br><b>Baltimore, Md.</b>                            |
| 24. FUNERAL DIRECTOR<br><b>James E. Bruzdinski</b>   |   | 25a. REC'D BY REGISTRAR<br><b>DEC 8 1967</b>   |   |
| 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>   |   |  |   |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 12 hours after death.

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |   |   |  |   |  |  |   |  |
|--|--|---|---|--|---|--|--|---|--|
| CERTIFICATE OF DEATH   |  |   |   |  |   |  |  |   |  |
| 1 PLACE OF DEATH<br>a COUNTY<br><b>Baltimore</b><br>b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Towson</b>   |  |   |   |  | 2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)<br>a STATE<br><b>Maryland</b><br>b COUNTY<br><b>Baltimore 21207</b> |  |  |   |  |
| c LENGTH OF STAY IN 1b   |  |   |   |  | c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Baltimore 21207</b>   |  |  |   |  |
| d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>ST. JOSEPH HOSPITAL</b>  |  |   |   |  | d STREET ADDRESS<br><b>5200 Gwynndale Ave.</b>  |  |  |   |  |
| e IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  |   |   |  |   |  |  |   |  |
| 3 NAME OF DECEASED<br>(Type or print)<br>First <b>Florence</b> Middle <b>L.</b> Last <b>SNYDER</b>   |  |   |   |  | 4 DATE OF DEATH<br>Month <b>December</b> Day <b>22</b> Year <b>19 67</b>  |  |  |   |  |
| 5 SEX<br><b>Female</b>   |  | 6. COLOR OR RACE<br><b>White</b>            |   | 7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 8 DATE OF BIRTH<br><b>August 3, 1897</b> |  | 9 AGE (In years last birthday)<br><b>70</b> yrs |  |
| 10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Homemaker</b>   |  | 10b KIND OF BUSINESS OR INDUSTRY            |   | 11 BIRTHPLACE (County & State, or foreign country)<br><b>Maryland</b>  |   |  | 12 CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                            |   |  |
| 13 FATHER'S NAME<br><b>George S. Lane</b>  |  |   |   |  | 14. MOTHER'S MAIDEN NAME<br><b>Clara A. Lamney</b>  |  |  |   |  |
| 15 WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) (If yes give war or dates of service)<br><b>No</b>   |  | 16 SOCIAL SECURITY NO<br><b>212-05-9359</b> |   | 17 INFORMANT<br><b>Mr. Arthur P. Munderloh, 1526 Fernley Rd.</b>   |   |  | Address <b>21218</b>   |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))   |  |   |   |  |   |  |  |   |  |
| PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Broncho-pneumonia</b>   |  |   |   |  |   |  |  |   |  |
| DUE TO (b) <b>Hepatic metastasis from carcinoma of colon</b>   |  |   |   |  |   |  |  |   |  |
| DUE TO (c)   |  |   |   |  |   |  |  |   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)<br><b>Coronary artery disease</b>   |  |   |   |  |   |  |  |   |  |
| 19 WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |   |   |  |   |  |  |   |  |
| 20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   |   |  | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)  |  |  |   |  |
| 20c TIME OF INJURY Month, Day, Year<br>Hour a.m. _____ p.m. <b>19</b>  |  |   | 20d INJURY OCCURRED<br>While <input type="checkbox"/> Not While <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/> |  | 20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |  | 20f (City or town) (County) (State)                                  |   |  |
| 21. I certify that <b>A</b> (this hospital) attended the deceased from <b>12/20/</b> , 19 <b>67</b> , to <b>12/22/</b> , 19 <b>67</b> that (I) (we) last saw the deceased alive on <b>12/22/</b> , 19 <b>67</b> , and that death occurred at <b>7 A.</b> M., from causes and on the date stated above. |  |   |   |  |   |  |  |   |  |
| 22a SIGNATURE<br><b>Keith A. Manley</b>  |  |   |   |  | M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>                      |  |  | 22b DATE SIGNED<br><b>12/22/67</b>              |  |
| 22c PHYSICIAN'S NAME (Type)<br><b>Keith A. Manley, M.D.</b>  |  |   |   |  | 22d ADDRESS<br><b>7503 Club Rd., Baltimore, Md. 21204</b>   |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |  | 23b DATE THEREOF<br><b>12/26/67</b>         |   | 23c NAME OF CEMETERY OR CREMATORY<br><b>Meadowride Memorial Pk.</b>  |   |  | 23d LOCATION (City or Town) (County) (State)<br><b>Baltimore Md.</b> |   |  |
| 24 FUNERAL DIRECTOR<br><b>Howard H. Hubbard, 4105 4107 Wilkens Ave. 21229</b>  |  |   |   |  | 25a REC'D BY REGISTRAR<br><b>DEC 27 1967</b>  |  | 25b REGISTRAR'S SIGNATURE<br><i>[Signature]</i>                      |   |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

1668

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

# CERTIFICATE OF DEATH

1667

|   |  |  |  |   |  |  |  |
|---|--|--|--|---|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Baltimore</u> MARYLAND  |  |  |  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>o. STATE <u>Maryland</u> b. COUNTY <u>—</u>                        |  |  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Citonsville</u>  |  |  |  | c. LENGTH OF STAY IN 1b   |  |  |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><u>TORRENT HAVEN NURS Home</u>  |  |  |  | d. STREET ADDRESS<br><u>120 N Potomac ST</u>  |  |  |  |
| 3. NAME OF DECEASED (Type or print)<br><u>Adam Sobotka</u>  |  |  |  | 4. DATE OF DEATH<br>Month <u>12</u> Day <u>11</u> Year <u>1967</u>  |  |  |  |
| 5. SEX<br><u>Male</u>   |  | 6. COLOR OR RACE<br><u>White</u>   |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><u>12-24-87</u>                                |  |
| 9. AGE (In years, months, days)<br><u>79</u> yrs  |  | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>LONG SHOREMAN</u> |  | 11. BIRTHPLACE (City, State, or foreign country)<br><u>Poland</u>   |  | 12. CITIZEN OF WHAT COUNTRY?<br><u>USA</u>                         |  |
| 13. FATHER'S NAME<br><u>FRANK SOBOTKA</u>   |  |  |  | 14. MOTHER'S MAIDEN NAME<br><u>TEOFIL ZWOTKOWSKA</u>  |  |  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><u>NO</u>  |  | 16. SOCIAL SECURITY NO<br><u>215-09-3327</u>   |  | 17. INFORMANT<br><u>MARY HATHAWAY 120 N. POTOMAC ST</u>   |  |  |  |
| 18. CAUSE OF DEATH (Enter on only one cause per line for (a), (b) and (c))<br>PART I DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <u>PNEUMONIA + PULMONARY EMBOLISM</u><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost }<br>(b) <u>PERIPHERAL VASCULAR DISEASE - VITROUS</u><br>DUE TO<br>(c) <u>MI</u> |  |  |  |   |  |  |  |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |  |  |  |   |  |  |  |
| 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)<br><input type="checkbox"/>  |  |  |  | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)  |  |  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. _____ p.m. _____ 19__   |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>          |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |  | 20f. (City or town) (County) (State)                               |  |
| 21. I certify that (I) (this hospital) attended the deceased from <u>7/23</u> , 19 <u>67</u> to <u>12/11</u> , 19 <u>67</u> that (I) (we) last saw the deceased alive on <u>12/11</u> , 19 <u>67</u> , and that death occurred at <u>11:00</u> M, from causes on and on the date stated above   |  |  |  |   |  |  |  |
| 22a. SIGNATURE<br><u>[Signature]</u>  |  |  |  | 22b. ADDRESS<br><u>5800 E. Main St. #21</u>   |  | 22c. DATE SIGNED<br><u>12/11/67</u>                                |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>BURIAL</u>  |  | 23b. DATE THEREOF<br><u>12-14-67</u>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><u>OAKLAWN CEM.</u>   |  | 23d. LOCATION (City or town) (County) (State)<br><u>Balto. Md.</u> |  |
| 24. FUNERAL DIRECTOR<br><u>JOHN M. WEBER &amp; SONS INC 401 S. CHESTER ST.</u>  |  |  |  | 25a. REC'D BY REG STRAR<br>DATE <u>DEC 12 1967</u>  |  | 25b. REG STRAR'S SIGNATURE<br><u>[Signature]</u>                   |  |

VR A15 (4)  
25M 1/67



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

|  |  |   |   |
|--|--|---|---|
| 16686  |  | 16680   |   |
| 1 PLACE OF DEATH<br>a COUNTY <b>BALTIMORE</b><br>b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>TOWSON</b>   |  | 2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a STATE <b>MARYLAND</b><br>b COUNTY                             |   |
| c LENGTH OF STAY IN TB <b>10 days</b>  |  | c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BALTIMORE</b>  |   |
| d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>ST. JOSEPH HOSPITAL</b>   |  | d STREET ADDRESS <b>4910 ROSS RD. #21214</b>  |   |
| 3 NAME OF DECEASED (Type or print) <b>AGNES M. SOLOMON</b>   |  | 4 DATE OF DEATH <b>DECEMBER 19 1967</b>   |   |
| 5 SEX <b>FEMALE</b>  | 6 COLOR OR RACE <b>WHITE</b>   | 7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8 DATE OF BIRTH <b>1889 7 8</b> AGE (In years last birthday) <b>78</b> yrs                    |
| 10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOMEMAKER</b>  |  | 10b KIND OF BUSINESS OR INDUSTRY <b>At Home</b>   |   |
| 11 BIRTHPLACE (County & State, or foreign country) <b>BALTIMORE, MARYLAND</b>  |  | 12 CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>   |   |
| 13 FATHER'S NAME <b>William CROUT</b>  |  | 14 MOTHER'S MAIDEN NAME <b>Agnes ETTINGER</b>   |   |
| 15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)   |  | 16 SOCIAL SECURITY NO.  |   |
| 17 INFORMANT <b>Stanley L Solomon</b>  |  | Address <b>Same</b>   |   |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY.<br>IMMEDIATE CAUSE (a) <b>Cerebro vascular accident (thrombosis)</b><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost }<br>(b) <b>cerebro arteriosclerosis</b><br>DUE TO<br>(c) <b>diabetes mellitus</b> |  |   | INTERVAL BETWEEN ONSET AND DEATH  |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |  |   | 19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOT BY MEDICAL EXAMINER)  |  | 20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)   |   |
| 20c TIME OF INJURY Month, Day, Year<br>Hour a.m. <b>19</b><br>p.m.   | 20d INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   | 20f (City or town) (County) (State)   |
| 21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>DECEMBER 9, 1967</b> , to <b>DECEMBER 19 1967</b> that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>DECEMBER 19 1967</b> , and that death occurred at <b>6:00 AM</b> from causes and on the date stated above                           |  |   |   |
| 22a SIGNATURE <b>Lawrence F. Misanik, M.D.</b>   |  | 22b DATE SIGNED <b>12/19/67</b>   |   |
| 22c PHYSICIAN'S NAME (Type) <b>Lawrence F. Misanik, M.D.</b>   |  | 22d ADDRESS <b>7620 York Rd., Towson, Md., 21204</b>  |   |
| 23a BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>   | 23b DATE THEREOF <b>12-22-1967</b>   | 23c NAME OF CEMETERY OR CREMATORY <b>Glen Haven Cemetery</b>  | 23d LOCATION (City or Town) (County) (State) <b>Glen Burnie Md</b>                            |
| 24 FUNERAL DIRECTOR <b>Chas F. Evanson</b>   |  | 25a REC'D BY REGISTRAR <b>8802 Hartford Rd</b>  |   |
| 25b REGISTRAR'S SIGNATURE <b>William J. Gudge</b>  |  | DATE <b>DEC 22 1967</b>   |   |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, pay the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

|   |  |   |  |
|---|--|---|--|
| 1 PLACE OF DEATH<br>a. COUNTY<br><b>Baltimore</b>   |  | 2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)<br>a. STATE <b>Maryland</b><br>b. COUNTY <b>Baltimore</b>              |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Mount Wilson</b>   |  | c. LENGTH OF STAY IN <b>11 mo. 1 day</b><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Baltimore</b>            |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>Mount Wilson State Hospital</b>  |  | d. STREET ADDRESS<br><b>700 Park Ave</b>  |  |
| 3. NAME OF DECEASED<br>(Type or print)<br><del>Edward E. Sprigg</del> <b>John E. SPRIGG</b>   |  | 4. DATE OF DEATH<br>Month <b>12</b> Day <b>18</b> Year <b>1967</b>  |  |
| 5. SEX<br><b>M</b>  | 6. COLOR OR RACE<br><b>W</b>   | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>9.25.1908</b>                                   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Bus driver</b>  |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Retired</b>   | 9. AGE (In years)<br><b>59</b> yrs                                     |
| 11 BIRTHPLACE (County & State or foreign country)<br><b>Maryland</b>  |  | 12 CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  |
| 13 FATHER'S NAME<br><b>JOHN SPRIGG</b>  |  | 14 MOTHER'S MAIDEN NAME<br><b>MODORA MOXLEY</b>   |  |
| 15 WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) <b>NO</b>   |  | 16 SOCIAL SECURITY NO<br><b>217-07-4005</b>   |  |
| 17 INFORMANT<br><b>Records, Mt. Wilson State Hospital</b>   |  | Address   |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY.<br>IMMEDIATE CAUSE (a) <b>Far advanced pulmonary tuberculosis</b><br>DUE TO (b) _____<br>DUE TO (c) _____   |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>2 years</b>  |  |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE (CONDITION GIVEN IN PART I (a))<br><b>Follicular lymphoma of mesenterium</b>   |  | 19 WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. _____ p.m. <b>19</b>  | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Not While <input type="checkbox"/><br>at work at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  | 20f. (City or town) (County) (State)                                   |
| 21. I certify that (I) (this hospital) attended the deceased from <b>1.17.</b> 19 <b>67</b> , to <b>12.18.</b> 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>12.18</b> 19 <b>67</b> , and that death occurred at <b>2:40 AM</b> , from causes and on the date stated above |  |   |  |
| 22a. SIGNATURE<br><b>Wm. Newcomer</b>   |  | 22b. DATE SIGNED<br><b>12.18.67.</b>  |  |
| 22c. PHYSICIAN'S NAME (Type)<br><b>Wm. Newcomer, M.D., Superintendent</b>   |  | 22d. ADDRESS<br><b>Mount Wilson, Maryland</b>   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  | 23b. DATE THEREOF<br><b>12/21/67.</b>  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Lorraine Park Cemetery</b>   | 23d. LOCATION (City or Town) (County) (State)<br><b>Baltimore, Md.</b> |
| 24. FUNERAL DIRECTOR<br><b>Leonard J. Ruck, Inc. Balto. Md. 21214</b>   |  | 25a. REC'D BY REGISTRAR<br>DATE <b>DEC 20 1967</b>  |  |
|   |  | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>  |  |





## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

|  |   |  |  |
|--|---|--|--|
| 1 PLACE OF DEATH<br>a COUNTY <b>Baltimore</b> MARYLAND   |   | 2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)<br>a STATE <b>Maryland</b> b COUNTY <b>Baltimore</b>   |  |
| b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Dundalk</b>  |   | c LENGTH OF STAY IN 1b<br><b>17 yrs.</b>   |  |
| d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>7421 School Avenue</b>   |   | d STREET ADDRESS<br><b>7421 School Avenue</b>  |  |
| 3 NAME OF DECEASED<br>(Type or print)<br><b>George Keister Steele</b>  |   | 4 DATE OF DEATH<br>Month <b>December</b> Day <b>8</b> Year <b>1967</b>   |  |
| 5 SEX<br><b>Male</b>   | 6 COLOR OR RACE<br><b>White</b>   | 7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>   | 8 DATE OF BIRTH<br><b>July 5, 1904</b>                               |
| 9 AGE (In years last birthday)<br><b>63</b> yrs  |   | IF UNDER 1 YEAR<br>Months <b>8</b> Days <b>19</b> Hours <b>67</b> Min  |  |
| 10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Guard</b>   |   | 10b KIND OF BUSINESS OR INDUSTRY<br><b>Paul Jones Co.</b>  | 11 BIRTHPLACE (State or foreign country)<br><b>Penna.</b>            |
| 12 CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |   | 13 FATHER'S NAME<br><b>George Steele</b>   |  |
| 14 MOTHER'S MAIDEN NAME<br><b>Eleanor Keister</b>  |   | 15 WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) (If yes give war or dates of service)<br><b>No</b>   |  |
| 16 SOCIAL SECURITY NO<br><b>716-07-4962</b>  |   | 17 INFORMANT<br>Address <b>Dundalk, Md.</b><br><b>(Wife) Ethel M. Steele 7421 School Avenue</b>  |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <b>Cancer of Colon</b><br>1050 DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Cervical Metastasis</b><br>DUE TO (c)   |   |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>14 mos</b>                    |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |   |  |  |
| 20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |   | 20b DESCRIBE HOW INJURY OCCURRED (Give nature of injury in Part I or Part II of Item 18)<br><b>X</b>   |  |
| 20c TIME OF INJURY Month, Day Year<br>Hour a.m. <b>19</b> p.m.   | 20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  | 20f (City or town) (County) (State)                                  |
| 21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> |   |  |  |
| ACTUAL SIGNATURE<br><b>M B Davis</b>   |   | 22. DATE SIGNED<br><b>12/9/67</b>  |  |
| EXAMINER'S NAME (Type)<br><b>Melvin B. Davis, M.D.</b>   |   | CHIEF MEDICAL EXAMINER <input type="checkbox"/><br>ASSISTANT MEDICAL EXAMINER <input type="checkbox"/><br>DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <b>6800 Morningside Rd</b><br>Address (Street, city, town or county) <b>Balto. Co. Md. 21222</b> |  |
| 23a BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  | 23b DATE THEREOF<br><b>Dec 11, 1967</b>   | 23c NAME OF CEMETERY OR CREMATORY<br><b>Oak Lawn Cemetery</b>  | 23d LOCATION (City or town) (County) (State)<br><b>Baltimore Md.</b> |
| 24 FUNERAL DIRECTOR<br><b>John J. Duda, 7922 Wise Ave. Dundalk, Md.</b>  |   | 25a REC'D BY REGISTRAR<br>DATE <b>DEC 12 1967</b>  |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, and in any event within 72 hours after death, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16689

CERTIFICATE OF DEATH

16683

|  |                                      |   |  |   |   |
|--|--------------------------------------|---|--|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY<br><b>Baltimore</b><br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Towson</b>  |                                      | c. LENGTH OF STAY IN 1b<br><b>Baltimore 21204</b>   |  | 2. USUAL RESIDENCE (Where deceased lived, if institution on Residence before admission)<br>a. STATE<br><b>Maryland</b><br>b. COUNTY<br><b>121</b> |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>ST. JOSEPH HOSPITAL</b>   |                                      | d. STREET ADDRESS<br><b>326 Dixie Dr.</b>   |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |   |
| 3. NAME OF DECEASED<br>(Type or print)<br>First <b>Anne</b> Middle <b>R</b> Last <b>STIELPER</b>   |                                      | 4. DATE OF DEATH<br>Month <b>December</b> Day <b>27</b> Year <b>19 67</b>   |  |   |   |
| 5. SEX<br><b>Female</b>  | 6. COLOR OR RACE<br><b>White</b>     | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>August 2, 1908</b>                              | 9. AGE (In years lost birthday)<br><b>59</b> yrs.   | IF UNDER 1 YEAR<br>Months <b>27</b> Days <b>19</b> Hours <b>67</b> Min.                           |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Homemaker</b>  |                                      | 10b. KIND OF BUSINESS OR INDUSTRY   |  | 11. BIRTHPLACE (County & State, or foreign country)<br><b>Baltimore, Maryland</b>   |   |
| 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |                                      | 13. FATHER'S NAME<br><b>Robert W Eigner</b>   |  |   |   |
| 14. MOTHER'S MAIDEN NAME<br><b>Loretta R North</b>   |                                      | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><b>No</b>  |  |   |   |
| 16. SOCIAL SECURITY NO.<br><b>None</b>   |                                      | 17. INFORMANT<br><b>Mr Andrew H Stielper</b>  |  | Address<br><b>Same</b>  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Massive gastro-intestinal bleeding</b><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>advanced liver cirrhosis</b><br>DUE TO<br>(c)                   |                                      |   |  |   | INTERVA. BETWEEN ONSET AND DEATH  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |                                      |   |  |   | 19. WAS AUTOPSY PERFORMED?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF OTHER, NOTIFY MEDICAL EXAMINER)  |                                      | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)  |  |   |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. <b>19</b> p.m.   |                                      | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Not While <input type="checkbox"/><br>at work at work  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State)  |   |
| 21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>11/29/</b> , 19 <b>67</b> , to <b>12/27/</b> , 19 <b>67</b> that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>12/27/</b> , 19 <b>67</b> , and that death occurred at <b>9:50M</b> , from causes and on the date stated above. |                                      |   |  |   |   |
| 22a. SIGNATURE<br><i>William</i>   |                                      | M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>                        |  | 22b. DATE SIGNED<br><b>12/27/67</b>   |   |
| 22c. PHYSICIAN'S NAME (Type)<br><b>Ines Cilliani, M.D.</b>   |                                      | 22d. ADDRESS<br><b>7620 York Rd., Towson, Md. 21204</b>   |  |   |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   | 23b. DATE THEREOF<br><b>12/30/67</b> | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Mt Maria</b>   |  | 23d. LOCATION (City or Town) (County) (State)<br><b>Baltimore Md 21204</b>  |   |
| 24. FUNERAL DIRECTOR<br><b>Leonard J Ruck Inc. 5305 Harford Rd</b>   |                                      | ADDRESS   |  | 25a. REC'D BY REGISTRAR<br>DATE <b>DEC 28 1967</b>  | 25b. REGISTRAR'S SIGNATURE<br><i>J. L. Jones</i>  |



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If only delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
6M 1/67

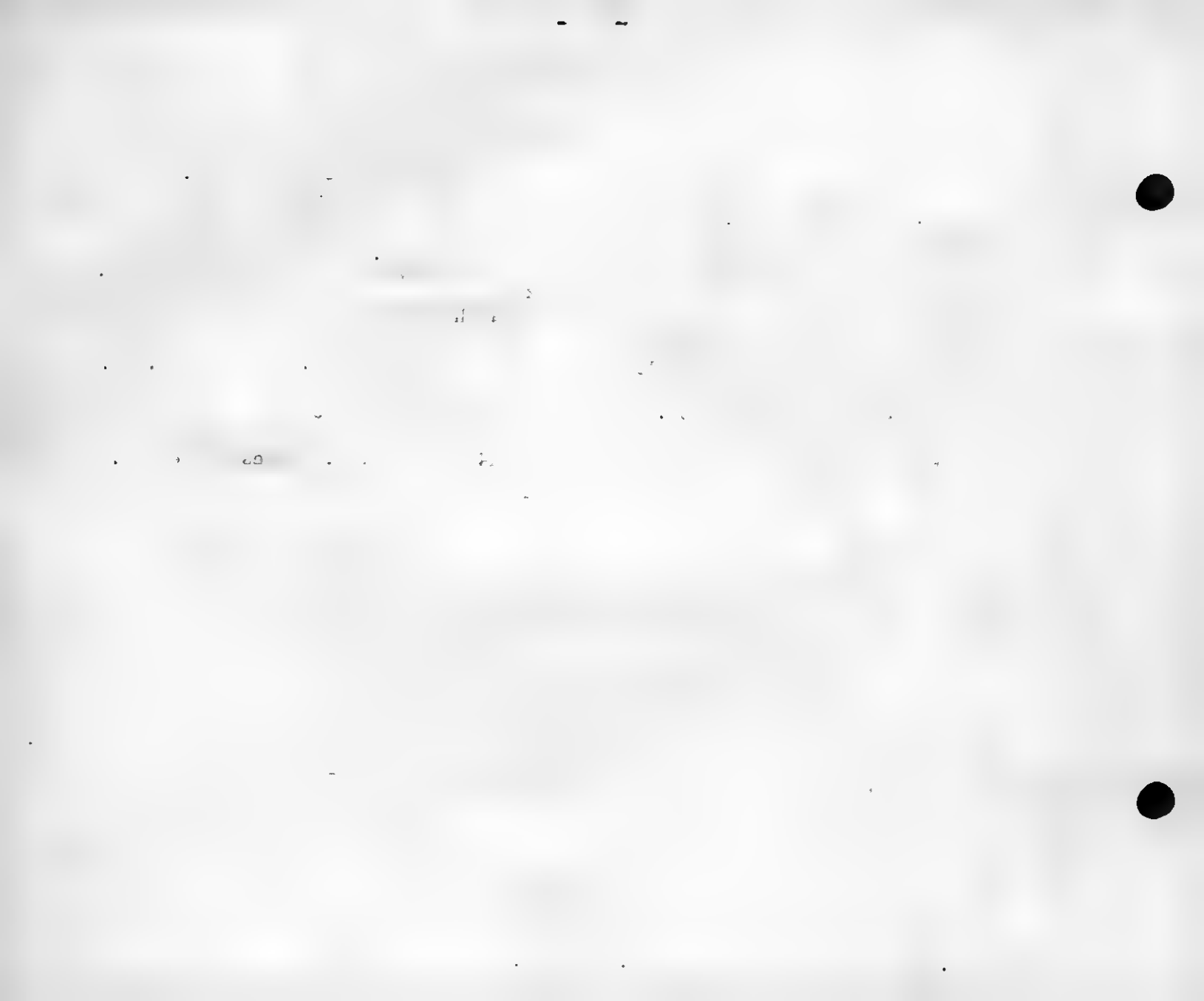
16690

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13684

|   |                                      |  |   |
|---|--------------------------------------|--|---|
| 1 PLACE OF DEATH<br>a. COUNTY <b>Baltimore</b> MARYLAND   |                                      | 2 USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>  |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)  |                                      | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)   |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>St. Joseph's Hospital</b>  |                                      | e. STREET ADDRESS <b>West Run Rd.<br/>c/o Frank Saitis</b>   |   |
| 3 NAME OF DECEASED (Type or print)<br>First <b>CHARLES</b> Middle <b>NMI</b> Last <b>STILIHAN, Jr.</b>  |                                      | 4 DATE OF DEATH<br>Month <b>December</b> Day <b>25</b> Year <b>1967</b>  |   |
| 5 SEX<br><b>Male</b>  | 6 COLOR OR RACE<br><b>White</b>      | 7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>  | 8 DATE OF BIRTH<br><b>MARCH 21, 1921</b><br><b>MARCH 27, 1920</b>         |
| 9 AGE (In years last birthday)<br><b>46</b> yrs   |                                      | 10 IF UNDER 1 YEAR<br>Months <b>3</b> Days <b>30</b> Hours <b>30</b> Min <b>30</b>   |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Farm Hand</b>   |                                      | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Dairy Farm</b>   |   |
| 11. BIRTHPLACE (State or foreign country)<br><b>Pittston, Pa.</b>   |                                      | 12 CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |   |
| 13. FATHER'S NAME<br><b>Charles Stiliha, Sr.</b>  |                                      | 14 MOTHER'S MAIDEN NAME<br><b>Anna Tomas</b>   |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><b>Yes W.W.II</b>  |                                      | 16. SOCIAL SECURITY NO.<br><b>?</b>  |   |
| 17. INFORMANT<br><b>XXXX Morris F. H. Wilkes-Barre, Pa.</b>   |                                      | Address <b>EXETER BORO</b>   |   |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <b>Multiple Injuries</b><br>DUE TO<br>(b) _____<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)                  |                                      | INTERVAL BETWEEN ONSET AND DEATH   |   |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |                                      | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18)<br><b>Pedestrian struck by car</b>  |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour <b>8:30</b> pm <b>12/25</b> 19 <b>67</b>   |                                      | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>   |   |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)<br><b>street</b>   |                                      | 20f. (City or town) (County) (State)<br><b>Baltimore, Md.</b>  |   |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> |                                      |  |   |
| ACTUAL SIGNATURE<br><b>Werner U. Spitz, M.D.</b>  |                                      | CHIEF MEDICAL EXAMINER <input type="checkbox"/><br>ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/><br>DEPUTY MEDICAL EXAMINER <input type="checkbox"/><br>Address (Street, city, town, or county) |   |
| 22. DATE SIGNED<br><b>12/26/67</b>  |                                      |  |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Removal</b>   | 23b. DATE THEREOF<br><b>12/26/67</b> | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Morris Funeral Home</b>   | 23d. LOCATION (City or town) (County) (State)<br><b>Wilkes-Barre, Pa.</b> |
| 24 FUNERAL DIRECTOR<br><b>Wm. Cook-Brooks, Inc. 1217 St. Paul St. Balto.</b>  |                                      | 25a. REC'D BY REGISTRAR<br><b>DEC 28 1967</b>  |   |
| 25b. REGISTRAR'S SIGNATURE<br><b>Wm. Cook-Brooks</b>  |                                      |  |   |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16691

CERTIFICATE OF DEATH

16685

|   |                                       |  |  |
|---|---------------------------------------|--|--|
| 1 PLACE OF DEATH<br>a. COUNTY <u>Baltimore</u> MARYLAND   |                                       | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)<br>a. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u>                    |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Perry Hall (rural)</u>   |                                       | c. LENGTH OF STAY IN 1b<br><u>1</u>  |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><u>Box 208 Cross Road</u>   |                                       | d. STREET ADDRESS<br><u>Box 208 Cross Road</u>   |  |
| 3 NAME OF DECEASED<br>(Type or print) First Middle Last<br><u>Anna C. Stocker</u>   |                                       | 4 DATE OF DEATH<br>Month <u>12</u> Day <u>26</u> Year <u>19 67</u>   |  |
| 5 SEX<br><u>Female</u>  | 6. COLOR OR RACE<br><u>Cau</u>        | 7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8 DATE OF BIRTH<br><u>6-2-7-1893</u>                                 |
| 9 AGE (In years last birthday)<br><u>74</u> yrs   |                                       | IF UNDER 1 YEAR<br>Months <u>12</u> Days <u>26</u> Hours <u>19</u> Min <u>67</u>   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Housewife</u>   |                                       | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>housewife</u>  |  |
| 11 BIRTHPLACE (County & State or foreign country)<br><u>Balto. Maryland</u>   |                                       | 12 CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>  |  |
| 13. FATHER'S NAME<br><u>George Hoffmann</u>   |                                       | 14. MOTHER'S MAIDEN NAME<br><u>Unknown</u>   |  |
| 15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><u>No</u>   |                                       | 16 SOCIAL SECURITY NO<br><u>212-22-5578</u>  |  |
| 17 INFORMANT<br><u>Mrs Pauline Brumgoole Cross Rd. Perry Hall</u>   |                                       | Address  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u><br>4201<br>DUE TO<br>Anteriosclerotic Cardiovascular Disease<br>DUE TO<br>(c)<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |                                       | INTERVAL BETWEEN ONSET AND DEATH<br><u>Sudden</u><br><u>2 yrs</u>  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |                                       |  |  |
| 20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                                       | 20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. <u>19</u> p.m.  |                                       | 20d INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>   |  |
| 20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |                                       | 20f (City or town) (County) (State)  |  |
| 21. I certify that (I) (this hospital) attended the deceased from <u>Nov 1</u> , 19 <u>67</u> , to <u>Dec 25</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>Dec 25</u> , 19 <u>67</u> , and that death occurred at <u>2:00 PM</u> , from causes and on the date stated above  |                                       |  |  |
| 22a SIGNATURE<br><u>M. Brumgoole</u> M.D.   |                                       | 22b. DATE SIGNED<br><u>12/27/67</u>  |  |
| 22c. PHYSICIAN'S NAME (Type)  |                                       | 22d. ADDRESS   |  |
| 23a BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial</u>   | 23b DATE THEREOF<br><u>12-27-1967</u> | 23c NAME OF CEMETERY OR CREMATORY<br><u>Holy Redeemer Cemetery</u>   | 23d LOCATION (City or Town) (County) (State)<br><u>Baltimore Md.</u> |
| 24. FUNERAL DIRECTOR<br><u>Joseph H. 7401 Belair Rd.</u>  |                                       | 25a REC'D BY REGISTRAR<br>DATE <u>JAN 2 1968</u>   |  |
| 25b REGISTRAR'S SIGNATURE   |                                       |  |  |





# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## CERTIFICATE OF DEATH

|   |  |   |   |
|---|--|---|---|
| 1 PLACE OF DEATH<br>a. COUNTY <u>BALTIMORE</u> MARYLAND   |  | 2 USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)<br>a. STATE <u>MARYLAND</u> b. COUNTY <u>BALTIMORE</u>             |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL</u>   |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BALTIMORE</u>   |   |
| c. LENGTH OF STAY IN 1b <u>3 YEARS</u>  |  |   |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>VILLA MARIA - NOTCH CLIFF</u>   |  | d. STREET ADDRESS <u>Glen Arm</u>   |   |
| e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  |   |   |
| 3 NAME OF DECEASED (Type or print) <u>Sister Mary EUSTACE STRASSNER</u>   |  | 4 DATE OF DEATH <u>12 - 2 19 67</u>   |   |
| 5 SEX <u>Female</u>   | 6 COLOR OR RACE <u>White</u>   | 7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8 DATE OF BIRTH <u>2-4-1893</u>   |
| 9 AGE (In years lost birthday) <u>74</u> yrs  |  | 10 IF UNDER 1 YEAR Months Days Hours Min  |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Teacher-Voice Mistress</u>   |  | 10b. KIND OF BUSINESS OR INDUSTRY <u>CONVENT</u>  |   |
| 11. BIRTHPLACE (County & State, or foreign country) <u>Rochester-New York</u>   |  | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>  |   |
| 13. FATHER'S NAME <u>George</u>   |  | 14. MOTHER'S MAIDEN NAME <u>Mary Lawrence</u>   |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>   |  | 16. SOCIAL SECURITY NO <u>220-54-6380-51</u>  |   |
| 17. INFORMANT <u>S. Catherine Mary-Villa Maria Hotel Cliff</u>  |  | Address <u>Blondin P.O. 21057</u>   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY.<br>IMMEDIATE CAUSE (a) <u>Diabetes Mellitus</u><br>DUE TO <u>260X</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Complications thereof</u><br>DUE TO (c) _____ |  |   | INTERVAL BETWEEN ONSET AND DEATH  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)  |  |   | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o m p.m. <u>19</u>   | 20d. INJURY OCCURRED<br>While o m Not While o m<br>at work <input type="checkbox"/> at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  | 20f. (City or town) (County) (State)  |
| 21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to <u>DEC. 2</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>Dec. 1</u> , 19 <u>67</u> , and that death occurred at <u>6:42 AM</u> , from causes and on the date stated above.  |  |   |   |
| 22a. SIGNATURE <u>Henry L. McCorke</u>  |  | 22b. DATE SIGNED  |   |
| 22c. PHYSICIAN'S NAME (Type) <u>HENRY L. MCCORKE MD</u>   |  | 22d. ADDRESS <u>Phoenix, Maryland 21131</u>   |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>   | 23b. DATE THEREOF <u>DEC. 5 1967</u>   | 23c. NAME OF CEMETERY OR CREMATORY <u>SISTERS CEMETERY</u>  | 23d. LOCATION (City or Town) (County) (State) <u>Glen Arm, Baltimore, Md.</u>       |
| 24. FUNERAL DIRECTOR <u>RAYMOND J. CURRAN</u>   |  | 25a. REC'D BY REGISTRAR <u>DEC 8 1967</u>   |   |
| 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>   |  |   |   |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 and direct, page 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



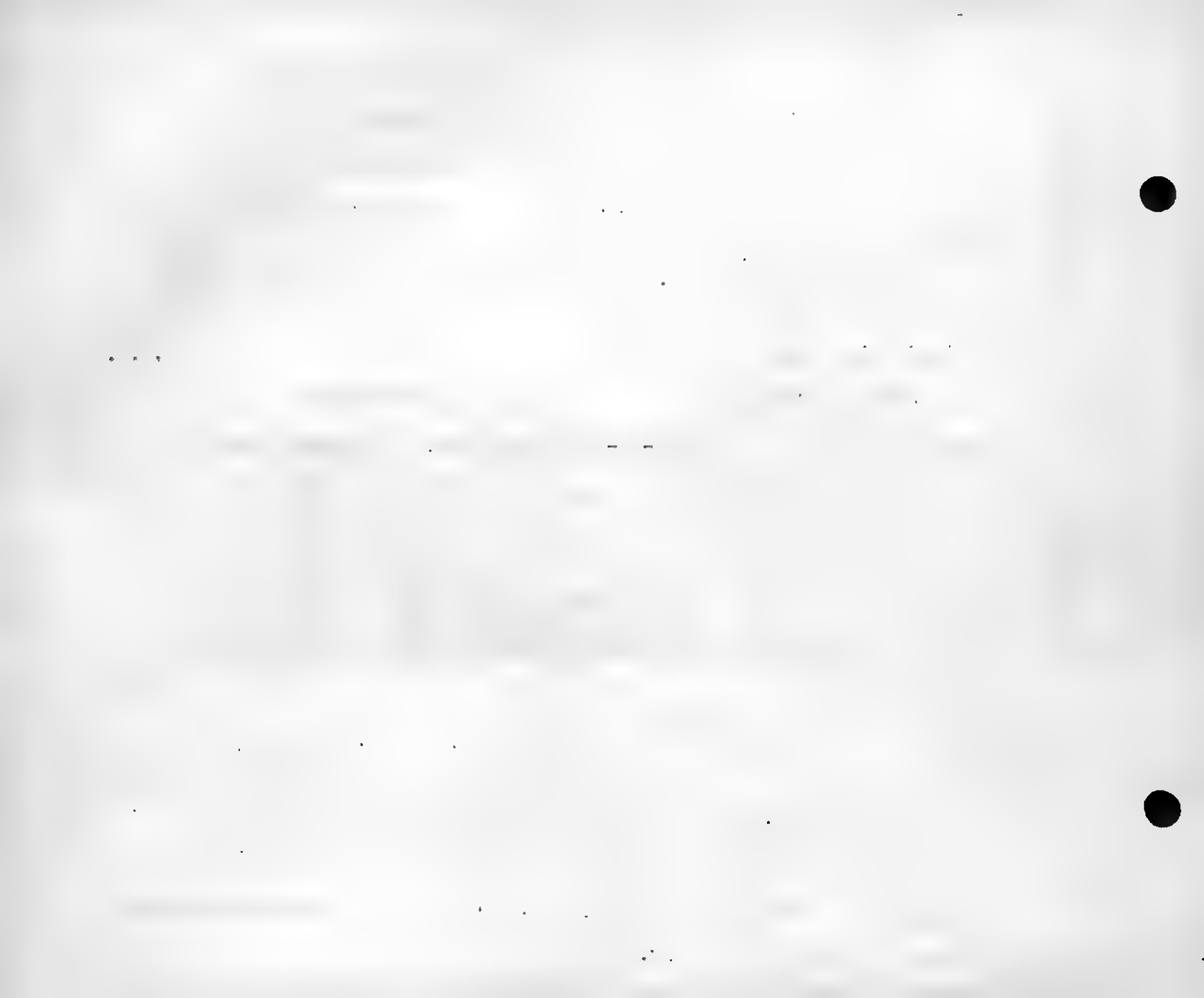
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
16693  
CERTIFICATE OF DEATH

|  |   |   |   |
|--|---|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY<br><b>Baltimore</b><br>b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)<br><b>Rural - Towson</b><br>c. LENGTH OF STAY IN 1b<br><b>49 days</b><br>d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)<br><b>Greater Baltimore Medical Center</b>  |   | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE<br><b>Maryland</b><br>b. COUNTY<br><b>Baltimore</b><br>c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)<br><b>Baltimore</b><br>d. STREET ADDRESS<br><b>2805 Louise Ave</b><br>e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |
| 3. NAME OF DECEASED (Type or print)<br>First Middle Last<br><b>Robert Cook Sturgeon</b>  |   | 4. DATE OF DEATH<br>Month Day Year<br><b>12 28 19 67</b>  |   |
| 5. SEX<br><b>Male</b>  | 6. COLOR OR RACE<br><b>Cau</b>  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>   | 8. DATE OF BIRTH<br><b>4/15/97</b>  |
| 9. AGE (In years last birthday)<br><b>70</b> yrs.  |   | 10. IF UNDER 1 YEAR IF UNDER 24 HRS.<br>Months Days Hours Min.  |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Retired Brick Layer</b>  |   | 10b. KIND OF BUSINESS OR INDUSTRY   |   |
| 11. BIRTHPLACE (County & State, or foreign country)<br><b>Maryland</b>   |   | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |   |
| 13. FATHER'S NAME<br><b>George Sturgeon</b>  |   | 14. MOTHER'S MAIDEN NAME<br><b>Emma Douglas</b>   |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><b>Yes WW 1</b>   |   | 16. SOCIAL SECURITY NO.<br><b>215-03-1080</b>   |   |
| 17. INFORMANT<br><b>Mrs Alma L Sturgeon</b>  |   | Address<br><b>Same</b>  |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Carcinoma of pancreas with wide spread metastases</b><br>DUE TO (b) _____<br>DUE TO (c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ |   |   |   |
| 19. WAS AUTOPSY PERFORMED?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |   |   |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)  |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m.<br><b>19</b>  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  | 20f. (City or town) (County) (State)                                      |
| 21. I certify that (I) (this hospital) attended the deceased from <b>11/9/</b> , <b>1967</b> , to <b>12/28, 1967</b> , that (I) (we) last saw the deceased alive on <b>12/27</b> , <b>1967</b> , and that death occurred at <b>5 a.m.</b> from the causes and on the date stated above.  |   |   |   |
| 22a. SIGNATURE<br><i>R. Breiteneker</i>  |   | 22b. DATE SIGNED<br><b>12/28/67</b>   |   |
| 22c. PHYSICIAN'S NAME (Type)<br><b>R. Breiteneker, M.D.</b>  |   | 22d. ADDRESS<br><b>6701 N. Charles Street</b>   |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   | 23b. DATE THEREOF<br><b>12/ 1/2/68</b>  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Gardens of Faith</b>   | 23d. LOCATION (City, town or county) (State)<br><b>Baltimore Maryland</b> |
| 24. FUNERAL DIRECTOR<br><b>Leonard J Ruck Inc 5305 Harford Rd</b>  |   | 25a. REC'D BY REGISTRAR<br><b>JAN 2 1968</b><br>25b. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>  |   |



CERTIFICATE OF DEATH

16688

|  |  |   |   |
|--|--|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Baltimore</b><br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Randallstown</b>  |  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <b>Maryland</b><br>b. COUNTY <b>Baltimore</b><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Randallstown</b> |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>Box 534 B McDonogh Rd Randallstown</b>  |  | d. STREET ADDRESS<br><b>Box 534 B McDonogh Rd</b>   |   |
| 3. NAME OF DECEASED<br>(Type or print) <b>John D Sudman Jr.</b>  |  | 4. DATE OF DEATH<br>Month <b>Dec</b> Day <b>17</b> Year <b>19 67</b>  |   |
| 5. SEX<br><b>Male</b>  | 6. COLOR OR RACE<br><b>White</b>   | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>   | 8. DATE OF BIRTH<br><b>Oct. 13, 1885</b>                                      |
| 9. AGE (In years last birthday) <b>82</b> yrs  |  | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Blacksmith</b>   |   |
| 11. BIRTHPLACE (County & State, or foreign country)<br><b>Randallstown, Balto Co Md</b>  |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |   |
| 13. FATHER'S NAME<br><b>John D. Sudman Sr.</b>   |  | 14. MOTHER'S MAIDEN NAME<br><b>Louise W. Lutz</b>   |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><b>no</b>   |  | 16. SOCIAL SECURITY NO.<br><b>219-32-0711</b>   |   |
| 17. INFORMANT<br><b>Ella E. Sudman</b>   |  | Address<br><b>Box 534 B McDonogh Rd</b>   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY.<br><b>177X Carcinoma of Prostate</b><br>IMMEDIATE CAUSE (a) <b>Carcinoma of Prostate</b><br>DUE TO (b) <b>Carcinoma of Prostate</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <b>Carcinoma of Prostate</b> |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>4 years</b>  |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)  |  |   |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1B)  |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. _____ p.m. <b>19</b>   | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  | 20f. (City or town) (County) (State)  |
| 21. I certify that (I) (this hospital) attended the deceased from _____, 19 <b>60</b> , to <b>Dec 17, 1967</b> , that (I) (we) lost saw the deceased alive on <b>12/17/67</b> 19____, and that death occurred at <b>7:30 PM</b> , from causes and on the date stated above.  |  |   |   |
| 22a. SIGNATURE<br><b>Dr. William Martin</b>  |  | 22b. DATE SIGNED  |   |
| 22c. PHYSICIAN'S NAME (Type)<br><b>Dr. William Martin</b>  |  | 22d. ADDRESS<br><b>Liberty Road Randallstown Md.</b>  |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   | 23b. DATE THEREOF<br><b>12/20/67</b>   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Mt Olive</b>   | 23d. LOCATION (City or town) (County) (State)<br><b>Randallstown BALTO MD</b> |
| 24. FUNERAL DIRECTOR<br><b>Spring Byers</b>  |  | 25a. REC'D BY REGISTRAR<br><b>8778 Liberty Rd Randallstown</b>  |   |
| 25b. REGISTRAR'S SIGNATURE<br><b>W. J. Judge</b>   |  | DATE <b>DEC 26 1967</b>   |   |

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

| <div>16695</div> <div>MARYLAND STATE DEPARTMENT OF HEALTH</div> <div>DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201</div> <div>CERTIFICATE OF DEATH</div> <div>16689</div>   |  |  |   |   |  |   |   |   |  |
|---|--|--|---|---|--|---|---|---|--|
| 1 PLACE OF DEATH<br>a. COUNTY <b>Baltimore</b> MARYLAND   |  |  |   |   | 2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> |   |   |   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Catonsville</b>  |  |  | c. LENGTH OF STAY IN lb<br><b>10 days</b> |   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><del>ATLANTA</del> <b>Baltimore Highlands</b>          |   |   |   |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>SPRING GROVE STATE HOSPITAL</b>  |  |  |   |   | d. STREET ADDRESS<br><b>2905 Louisiana Avenue</b>  |   |   | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 3 NAME OF DECEASED<br>(Type or print)<br>First Middle Last<br><b>Charles Ray Sullivan</b>   |  |  |   |   | 4 DATE OF DEATH<br>Month Day Year<br><b>December 12 19 67</b>  |   |   |   |  |
| 5 SEX<br><b>male</b>  |  | 6 COLOR OR RACE<br><b>white</b>  |   | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8 DATE OF BIRTH<br><b>Feb. 23, 1908</b> |   | 9 AGE (In years, less birthday) yrs<br><b>59</b>  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>handy man</b>   |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>American Ice Co.</b>   |   | 11 BIRTHPLACE (County & State, or foreign country)<br><b>Maryland</b>   |  |   | 12 CITIZEN OF WHAT COUNTRY?<br><b>U. S. A.</b>                              |   |  |
| 13 FATHER'S NAME<br><del>XXXXXXXXXXXX</del> <b>Raymond R. Sullivan</b>  |  |  |   |   | 14. MOTHER'S MAIDEN NAME<br><b>Ida Mendell</b>   |   |   |   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) (If yes give war or dates of service)  |  | 16. SOCIAL SECURITY NO.<br><b>214-01-5080</b>  |   | 17 INFORMANT<br>Address<br><b>Records: SPRING GROVE STATE HOSPITAL</b>  |  |   |   |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <b>Pulmonary Embolism, suspected,</b><br>DUE TO<br>(b) <b>Varicose Veins, Moderate, Bilateral</b><br>DUE TO<br>(c) <b>10 years.</b>                                   |  |  |   |   |  |   |   |   | INTERVAL BETWEEN ONSET AND DEATH<br><b>1 yr.</b>   |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)<br><b>Alcoholism, Chronic; Delirium Tremens, early; ASCVH Disease</b>   |  |  |   |   |  |   |   |   | 19 WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)                   |   |   |  |   |   |   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m. 19   |  | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Not While <input type="checkbox"/><br>at work at work |   | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc)   |  | 20f. (City or town) (County) (State)    |   |   |  |
| 21. I certify that (if this hospital) attended the deceased from <b>Dec. 2</b> , 19 <b>67</b> , to <b>Dec. 12</b> , 19 <b>67</b> , that (we) (we) last saw the deceased alive on <b>Dec. 12</b> , 19 <b>67</b> , and that death occurred at <b>3:15</b> M, from causes and on the date stated above |  |  |   |   |  |   |   |   |  |
| 22a. SIGNATURE<br><i>Anthony J. Young</i><br>M.D.   |  |  |   |   | ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>               |   |   | 22b. DATE SIGNED<br><b>12-13-67</b>   |  |
| 22c. PHYSICIAN'S NAME (Type)<br><b>Anthony J. Young, M.D.</b>   |  |  |   |   | 22d. ADDRESS<br><b>SPRING GROVE STATE HOSPITAL<br/>Baltimore, Maryland 21228</b>   |   |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>  |  | 23b. DATE THEREOF<br><b>12-16-1967</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Mt. Olivet Cemetery</b>  |  |   | 23d. LOCATION (City or town) (County) (State)<br><b>Baltimore, Maryland</b> |   |  |
| 24 FUNERAL DIRECTOR<br><b>Howard H. Hubbard, 4107 Wilkens Avenue 21229</b>  |  |  |   |   | 25a. REC'D BY REGISTRAR<br>DATE <b>DEC 15 1967</b>   |   | 25b. REGISTRAR'S SIGNATURE<br><i>Charles J. [unclear]</i>                   |   |  |





76696

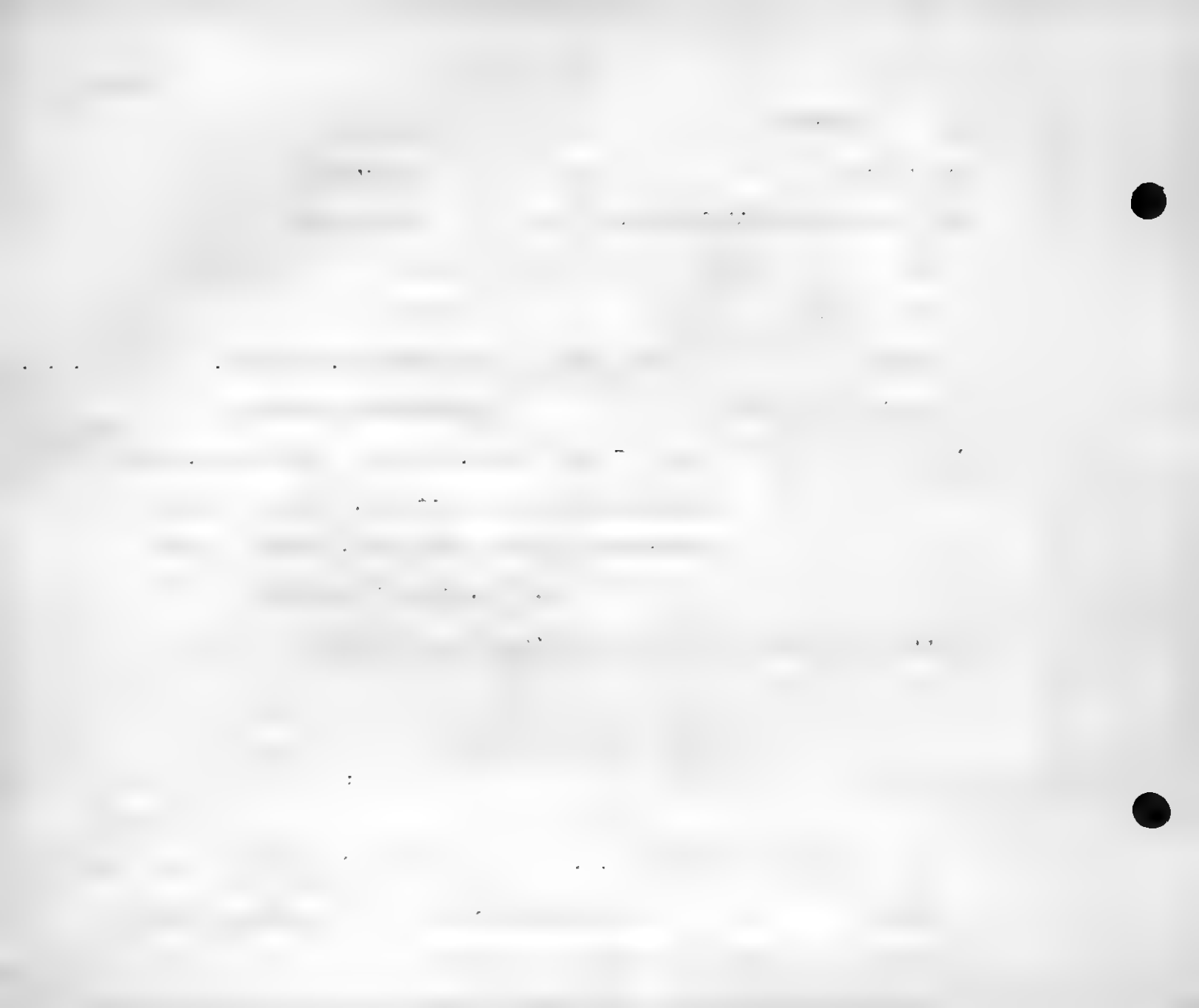
## CERTIFICATE OF DEATH

|   |  |   |   |
|---|--|---|---|
| 1 PLACE OF DEATH<br>a. COUNTY <b>BALTIMORE</b> MARYLAND   |  | 2 USUAL RESIDENCE (Where deceased lived, if institut on: Residence before admission)<br>a. STATE <b>MARYLAND</b> b. COUNTY                                  |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>PORT HOWARD</b>  |  | c. LENGTH OF STAY IN 1b<br><b>10 DAYS</b>   |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>VETERANS ADMINISTRATION HOSPITAL</b>   |  | d. STREET ADDRESS<br><b>319 PARK AVENUE</b>   |   |
| 3 NAME OF DECEASED (Type or print)<br>First <b>JOHN</b> Middle <b>LEWIS</b> Last <b>SULLIVAN</b>  |  | 4 DATE OF DEATH<br>Month <b>DECEMBER</b> Day <b>8</b> Year <b>19 67</b>   |   |
| 5. SEX<br><b>MALE</b>   | 6. COLOR OR RACE<br><b>WHITE</b>   | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>11/23/91</b>   |
| 9 AGE (In years last birthday)<br><b>76</b> yrs   |  | 10. IF UNDER 1 YEAR<br>Months Days Hours Min  |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>MANAGER</b>   |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>RACE TRACK</b>  |   |
| 11 BIRTHPLACE (County & State, or foreign country)<br><b>MARTINSBURG, WEST VA.</b>  |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |   |
| 13. FATHER'S NAME<br><b>PATRICK L SULLIVAN</b>  |  | 14. MOTHER'S MAIDEN NAME<br><b>CATHERINE B MAHONEY</b>  |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><b>YES WW I</b>  |  | 16. SOCIAL SECURITY NO<br><b>265 07 90 95</b>   |   |
| 17. INFORMANT<br><b>CLIN. RECORDS, VA HOSPITAL, PORT HOWARD,</b>  |  | Address <b>MARYLAND</b>   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I DEATH CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Bronchopneumonia, bilateral, undet. organism</b><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. }<br>(b) <b>Metastases to Lt. kidney, Lt. Adrenal gland</b><br>DUE TO<br>(c) <b>Tumor of lung, RLL, unspecified type</b> |  |   | INTERVAL BETWEEN ONSET AND DEATH<br><b>?</b>  |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br><b>Remote myocardial infarction; Interstitial pulmonary fibrosis</b>  |  |   | 19. WAS AUTOPSY PERFORMED?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)  |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m. <b>19</b>  | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Not While <input type="checkbox"/><br>at work at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  | 20f. (City or town) (County) (State)  |
| 21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>11/28/67</b> , 19 to <b>12/8/67</b> , 19, that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>12/8/67</b> , 19, and that death occurred at <b>4:00 PM</b> , from causes and on the date stated above.  |  |   |   |
| 22a. SIGNATURE<br><i>Neilon Neilson</i>   |  | 22b. DATE SIGNED<br><b>12/8/67</b>  |   |
| 22c. PHYSICIAN'S NAME (Type)<br><b>NEILON NEILSON, M.D.</b>   |  | 22d. ADDRESS<br><b>VA HOSPITAL, PORT HOWARD, MARYLAND</b>   |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>  | 23b. DATE THEREOF<br><b>12-12-67</b>   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>BALTIMORE NATIONAL</b>   | 23d. LOCATION (City or Town) (County) (State)<br><b>BALTIMORE, MARYLAND</b>                       |
| 24. FUNERAL DIRECTOR<br><b>EVANS FUNERAL HOME, 8802 HARFORD RD, BALTO</b>   |  | 25a. REC'D BY REGISTRAR<br><b>DEC 12 1967</b>   | 25b. REGISTRAR'S SIGNATURE<br><i>Charles Judge</i>  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



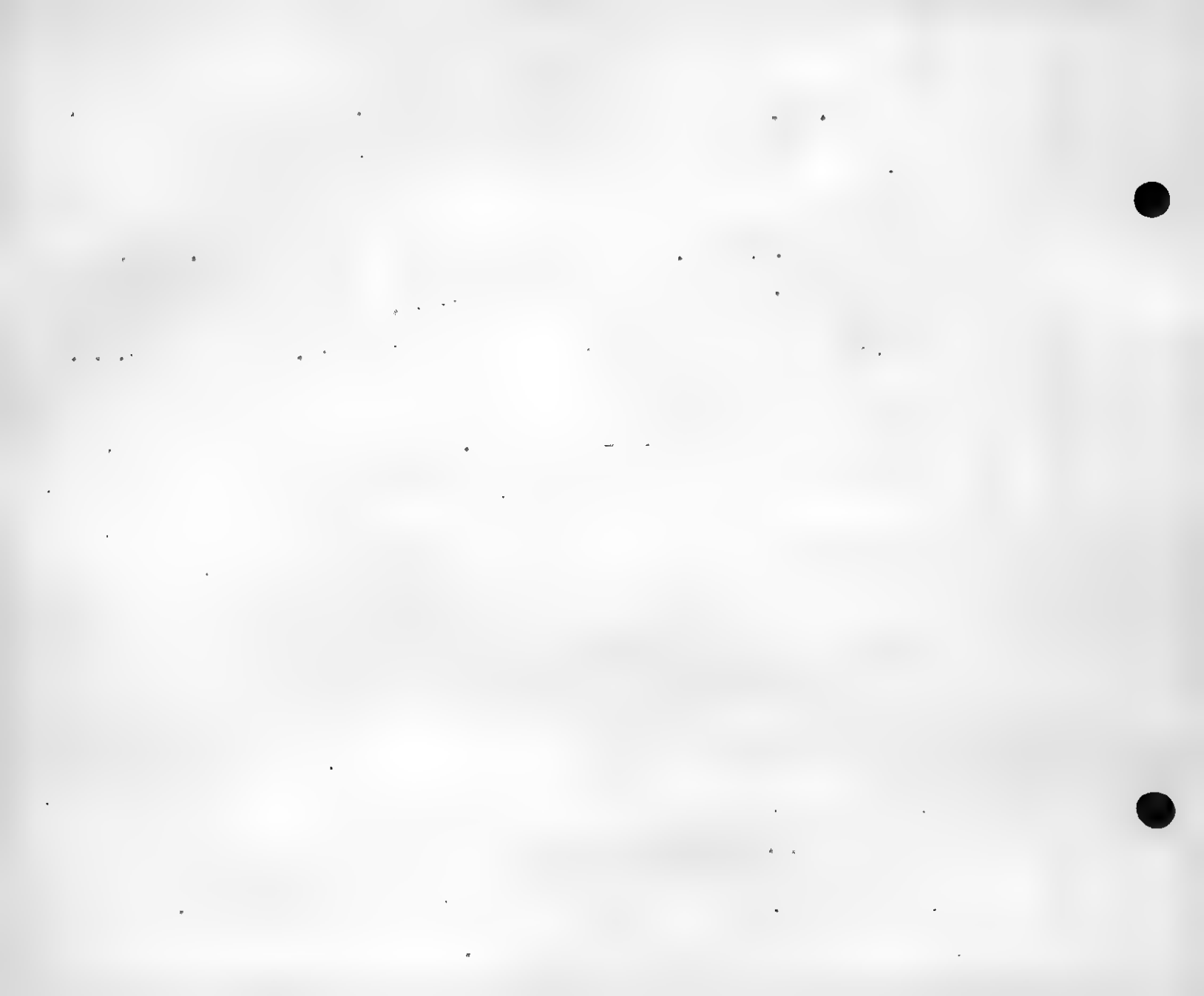
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon, paper, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

|   |                               |  |  |
|---|-------------------------------|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Balto. Co.</b><br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Boring</b><br>c. LENGTH OF STAY IN 1b<br><b>Boring</b><br>d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Box 48</b>  |                               | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <b>Md.</b><br>b. COUNTY <b>Balto. Co.</b><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Boring</b><br>d. STREET ADDRESS <b>Box 48</b><br>e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Albert</b> Middle <b>P.</b> Last <b>Sweisford</b>   |                               | 4. DATE OF DEATH<br>Month <b>Dec.</b> Day <b>21</b> Year <b>1967</b>   |  |
| 5. SEX <b>Male</b>  | 6. COLOR OR RACE <b>White</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>  | 8. DATE OF BIRTH <b>April 29, 1894</b> |
| 9. AGE (In years last birthday) <b>73</b> yrs.  |                               | 10. IF UNDER 1 YEAR IF UNDER 24 HRS.<br>Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Chauffeur</b>  |                               | 10b. KIND OF BUSINESS OR INDUSTRY <b>Trucking</b>  |  |
| 11. BIRTHPLACE (County & State, or foreign country) <b>Danville Pa.</b>   |                               | 12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>   |  |
| 13. FATHER'S NAME <b>John Sweisford</b>   |                               | 14. MOTHER'S MAIDEN NAME <b>Elizabeth Eckert</b>   |  |
| 15. WAS DECEASED EVER IN U.S. ARMY FORCES? (Yes, no, or unknown) <b>NO</b>  |                               | 16. SOCIAL SECURITY NO. <b>220-14-3521A</b>  |  |
| 17. INFORMANT <b>Mrs. Thelma Sweisford</b>  |                               | Address <b>Boring, Md.</b>   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Myocardial Failure</b><br>DUE TO (b) <b>Pyo-nephrosis</b><br>DUE TO (c) <b>Benign Hypertrophy of Prostate</b><br>CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last. |                               | INTERVAL BETWEEN ONSET AND DEATH <b>6-7 yrs</b>  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)  |                               |  |  |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                               |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                               | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. <b>19</b> p.m. <b>19</b>  |                               | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>  |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |                               | 20f. (City or town) (County) (State)   |  |
| 21. I certify that (1) (this hospital) attended the deceased from <b>June</b> , 19 <b>65</b> , to <b>Dec. 21</b> , 19 <b>67</b> , that (2) (we) last saw the deceased alive on <b>Dec. 20</b> , 19 <b>67</b> , and that death occurred at <b>1:30 AM</b> , from the causes and on the date stated above.  |                               |  |  |
| 22a. SIGNATURE <b>M.C. Porterfield</b>  |                               | 22b. DATE SIGNED <b>12-21-67</b>   |  |
| 22c. PHYSICIAN'S NAME (Type) <b>M.C. Porterfield</b>  |                               | 22d. ADDRESS <b>HAMPSTEAD, MD</b>  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>   |                               | 23b. DATE THEREOF <b>Dec. 23, 1967</b>   |  |
| 23c. NAME OF CEMETERY OR CREMATORY <b>Odd Fellows Cemetery</b>  |                               | 23d. LOCATION (City, town or county) (State) <b>Danville Pa.</b>   |  |
| 24. FUNERAL DIRECTOR <b>Tipton - Eline Funeral Home</b>   |                               | 25a. REC'D BY REGISTRAR <b>DEC 29 1967</b>   |  |
| ADDRESS <b>Hampstead, Md.</b>   |                               | 25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>  |  |

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

16698

16692

|   |  |   |  |  |  |  |   |
|---|--|---|--|--|--|--|---|
| 1 PLACE OF DEATH<br>a. COUNTY <b>Baltimore</b><br>MARYLAND  |  |   |  | 2. USUAL RESIDENCE (Where deceased lived, if not in an Residence before admission)<br>a. STATE <b>Md.</b><br>b. COUNTY <b>Baltimore</b>                    |  |  |   |
| b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Towson</b>  |  | c LENGTH OF STAY IN 1b  |  | c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Towson</b>   |  |  |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>609 Coventry Rd.</b>   |  |   |  | d STREET ADDRESS<br><b>609 Coventry Rd.</b>  |  | e IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |
| 3 NAME OF DECEASED<br>(Type or print)<br><b>Georgina</b> First <b>L</b> Middle <b>Tabeling</b> Last   |  |   |  | 4. DATE OF DEATH<br>Month <b>12</b> Day <b>19</b> Year <b>67</b>   |  |  |   |
| 5. SEX<br><b>Female</b>   |  | 6. COLOR OR RACE<br><b>White</b>  |  | 7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8 DATE OF BIRTH<br><b>8/26/1899</b>  |   |
| 9 AGE (In years last birthday)<br><b>68</b> yrs   |  | 10 IF UNDER 1 YEAR<br>Months Days Hours Min   |  | 11 BIRTHPLACE (County & State or foreign country)<br><b>Baltimore, Md.</b>   |  | 12 COUNTRY OF WHAT COUNTRY?<br><b>USA</b>  |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Homemaker</b>   |  |   |  | 10b. KIND OF BUSINESS OR INDUSTRY  |  | 11 BIRTHPLACE (County & State or foreign country)<br><b>Baltimore, Md.</b>                       |   |
| 13. FATHER'S NAME<br><b>George Schuchhardt</b>  |  |   |  | 14. MOTHER'S MAIDEN NAME<br><b>Katherine Helldorfer</b>  |  |  |   |
| 15 WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) <b>no</b> (If yes give war or dates of service)   |  | 16 SOCIAL SECURITY NO.<br><b>215-58-4830</b>  |  | 17 INFORMANT<br>Address<br><b>William J. Tabeling 609 Coventry Rd.</b>   |  |  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)).<br>PART I. DEATH WAS CAUSED BY:<br><b>550 IMMEDIATE CAUSE (a) PROGRESSIVE BULBAR PALSY</b><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(b)<br>DUE TO<br>(c) |  |   |  |  |  |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>6 mos</b>                                      |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)   |  |   |  |  |  |  | 19 WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)   |  | 20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1B)                   |  |  |  |  |   |
| 20c TIME OF INJURY Month, Day, Year<br>Hour a.m. 19<br>p.m.   |  | 20d INJURY OCCURRED<br>While <input type="checkbox"/> Not While <input type="checkbox"/><br>at work at work |  | 20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc)   |  | 20f (City or town) (County) (State)  |   |
| 21. I certify that (I) (this hospital) attended the deceased from <b>Dec. 11, 1967</b> , to <b>Dec. 19, 1967</b> , that (I) (we) last saw the deceased alive on <b>Dec. 18, 1967</b> , and that death occurred at <b>3 P.M.</b> from causes and on the date stated above                                |  |   |  |  |  |  |   |
| 22a. SIGNATURE<br><b>S.J. Venable Jr.</b>   |  |   |  | 22b. DATE SIGNED<br><b>12-20-67</b>  |  | 22c. PHYSICIAN'S NAME (Type)<br><b>S.J. Venable Jr.</b>  |   |
| 23a. BIRTH, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |  | 23b. DATE THEREOF<br><b>12/21/67</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Baltimore Cemetery</b>  |  | 23d. LOCATION (City or Town) (County) (State)<br><b>Baltimore Md.</b>                            |   |
| 24 FUNERAL DIRECTOR<br><b>Mitchell Wiedefeld Home 6500 York Rd.</b>   |  |   |  | 25a REC'D BY REGISTRAR<br>DATE <b>DEC 29 1967</b>  |  | 25b. REGISTRAR'S SIGNATURE   |   |



## CERTIFICATE OF DEATH

16693

16693

|   |                                       |  |   |
|---|---------------------------------------|--|---|
| 1 PLACE OF DEATH<br>a. COUNTY <i>Baltimore</i><br>MARYLAND  |                                       | 2 USUAL RESIDENCE (Where deceased lived, if institut an Residence before admission)<br>a. STATE <i>Md.</i><br>b. COUNTY <i>Balto.</i>                      |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><i>Reisterstown</i>   |                                       | c. LENGTH OF STAY IN 1b<br><i>Reisterstown</i>   |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><i>Cropeil Hill Nursing Home</i>  |                                       | d. STREET ADDRESS<br><i>311 Main Street</i>  |   |
| 3 NAME OF DECEASED<br>(Type or print)<br><i>Eunice</i> First <i>E.</i> Middle <i>Talbert</i> Last   |                                       | 4. DATE OF DEATH<br>Month <i>December</i> Day <i>2</i> Year <i>67</i>  |   |
| 5 SEX<br><i>Female</i>  | 6. COLOR OR RACE<br><i>White</i>      | 7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><i>Aug. 31, 1902</i>                              |
| 9 AGE (In years last birthday) yrs<br><i>65</i>   |                                       | IF UNDER 1 YEAR<br>Months <i>0</i> Days <i>0</i>   |   |
| 10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><i>Housewife</i>  |                                       | 10b KIND OF BUSINESS OR INDUSTRY   |   |
| 11 BIRTHPLACE (County & State, or foreign country)<br><i>Virginia</i>   |                                       | 12 CITIZEN OF WHAT COUNTRY<br><i>USA</i>   |   |
| 13 FATHER'S NAME<br><i>Unknown</i>  |                                       | 14 MOTHER'S MAIDEN NAME<br><i>Lydia Southard</i>   |   |
| 15 WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) (If yes give war or dates of service)<br><i>No</i>  |                                       | 16 SOCIAL SECURITY NO.   |   |
| 17. INFORMANT<br><i>Mr. Henry J. Talbert</i>  |                                       | Address<br><i>Reisterstown, Md.</i>  |   |
| 18. CAUSE OF DEATH (Enter on any one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <i>Carcinoma of stomach</i><br>DUE TO <i>Colitis</i><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last <i>Cachexia</i><br>DUE TO <i>Cachexia</i><br>(b) <i>Cachexia</i><br>(c) <i>Cachexia</i> |                                       | INTERVAL BETWEEN ONSET AND DEATH<br><i>1 yr</i><br><i>4 yrs</i><br><i>6 mos</i>  |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)  |                                       |  |   |
| 20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                                       | 20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)  |   |
| 20c TIME OF INJURY Month, Day, Year<br>Hour a.m. <i>19</i> p.m. <i>✓</i>  |                                       | 20d INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>   |   |
| 20e PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)  |                                       | 20f (City or town) (County) (State)  |   |
| 21. I certify that (I) (this hospital) attended the deceased from <i>1-1-1946</i> to <i>12-2-1967</i> , that (I) (we) last saw the deceased alive on <i>12-1-1967</i> , and that death occurred at <i>4:30</i> M, from causes and on the date stated above.   |                                       |  |   |
| 22a SIGNATURE<br><i>James G. Saffell</i>  |                                       | 22b. DATE SIGNED   |   |
| 22c PHYSICIAN'S NAME (Type)<br><i>James G. Saffell</i>  |                                       | 22d ADDRESS<br><i>Reisterstown, Md.</i>  |   |
| 23a BURIAL, CREMATION, REMOVAL (Specify)<br><i>Burial</i>   | 23b DATE THEREOF<br><i>Dec. 5, 67</i> | 23c NAME OF CEMETERY OR CREMATORY<br><i>Evergreen Memorial</i>   | 23d LOCATION (City or Town) (County) (State)<br><i>Finksburg, Md.</i> |
| 24 FUNERAL DIRECTOR<br><i>J. F. Eline &amp; Sons</i>  |                                       | ADDRESS<br><i>Reisterstown, Md.</i>  |   |
| 25a REC'D BY REGISTRAR<br>DATE <i>DEC 4 1967</i>  |                                       | 25b REGISTRAR'S SIGNATURE<br><i>Charles Judge</i>  |   |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

VR A15 (4)  
25M 1/67

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 4 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.





## CERTIFICATE OF DEATH

16694

16700

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

|   |                                  |  |   |
|---|----------------------------------|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY<br><b>Baltimore</b><br>b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town)<br><b>Towson</b>  |                                  | 2. USUAL RESIDENCE (Where deceased lived, if institution - Residence before admission)<br>a. STATE<br><b>Maryland</b><br>b. COUNTY<br><b>Baltimore</b>   |   |
| c. LENGTH OF STAY IN 1b<br><b>21234</b>   |                                  | d. STREET ADDRESS<br><b>7105 Harford Rd.</b>   |   |
| 3. NAME OF DECEASED<br>(Type or print)<br><b>Edna</b>   |                                  | 4. DATE OF DEATH<br>Month <b>December</b> Day <b>26</b> Year <b>1967</b>   |   |
| 5. SEX<br><b>Female</b>   | 6. COLOR OR RACE<br><b>White</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>Nov. 17 1913</b> |
| 9. AGE (in years last birthday)<br><b>54</b> yrs  |                                  | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)   |   |
| 11. BIRTHPLACE (County & State, or foreign country)<br><b>Maryland</b>  |                                  | 12. CITIZEN OF WHAT COUNTRY?   |   |
| 13. FATHER'S NAME<br><b>Robt S. TATE</b>  |                                  | 14. MOTHER'S MAIDEN NAME<br><b>Agnes M. Gaubert</b>  |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)   |                                  | 16. SOCIAL SECURITY NO.<br><b>213-16-5413</b>  |   |
| 17. INFORMANT<br><b>Brother</b>   |                                  | Address<br><b>Same</b>   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))  |                                  |  |   |
| PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Massive aspiration of blood of both lung</b>   |                                  |  |   |
| DUE TO (b) <b>rupture of varicose esophageal veins secondary to portal liver cirrhosis.</b>   |                                  |  |   |
| DUE TO (c)  |                                  |  |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |                                  |  |   |
| 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |                                  |  |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                                  | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)   |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. _____ p.m. <b>19</b>  |                                  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>  |   |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |                                  | 20f. (City or town) (County) (State)   |   |
| 21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>12/22/</b> 19 <b>67</b> to <b>12/26/</b> 19 <b>67</b> that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>12/26/</b> 19 <b>67</b> and that death occurred at <b>8:30AM</b> , from causes and on the date stated above. |                                  |  |   |
| 22a. SIGNATURE<br><b>William</b>  |                                  | 22b. DATE SIGNED<br><b>12/26/67</b>  |   |
| 22c. PHYSICIAN'S NAME (Type)<br><b>Ines Cilliani, M.D.</b>  |                                  | 22d. ADDRESS<br><b>7620 York Rd., Towson, Md. 21204</b>  |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)   |                                  | 23b. DATE THEREOF<br><b>12/30/67</b>   |   |
| 23c. NAME OF CEMETERY OR CREMATORY<br><b>London Park</b>  |                                  | 23d. LOCATION (City or town) (County) (State)<br><b>Baltimore</b>  |   |
| 24. FUNERAL DIRECTOR<br><b>W. Beermann 6667 Bay Rd</b>  |                                  | 25a. REC'D BY REGISTRAR<br><b>JAN 2 1968</b>   |   |
| 25b. REGISTRAR'S SIGNATURE  |                                  |  |   |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16701

CERTIFICATE OF DEATH

10695

|   |  |   |  |
|---|--|---|--|
| 1 PLACE OF DEATH<br>a. COUNTY <b>BALTIMORE</b> MARYLAND   |  | 2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)<br>a. STATE <b>MARYLAND</b> b. COUNTY <b>—</b>                     |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>FORT HOWARD</b>  |  | c. LENGTH OF STAY IN 1b<br><b>1 1/2 HOURS</b>   |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>VETERANS ADMINISTRATION HOSPITAL</b>   |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |
| 3 NAME OF DECEASED<br>(Type or print) First Middle Last<br><b>TAYLOR -- TAZEWEILL</b>   |  | 4 DATE OF DEATH<br>Month Day Year<br><b>DECEMBER 7 1967</b>   |  |
| 5 SEX<br><b>MALE</b>  | 6. COLOR OR RACE<br><b>NEGRO</b>   | 7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>4/7/1897 70</b>                                     |
| 9 AGE (In years birth day) yrs<br><b>70</b>   |  | 10. IF UNDER 1 YEAR<br>Months Days Hours Min.   | 11. IF UNDER 24 HRS<br>Months Days Hours Min.                              |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>FARMER</b>  |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>FARM</b>  |  |
| 11. BIRTHPLACE (County & State, or foreign country)<br><b>GLOUCESTER, VIRGINIA</b>  |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  |
| 13. FATHER'S NAME<br><b>WILLIAM TAZEWEILL</b>   |  | 14. MOTHER'S MAIDEN NAME<br><b>MARY ELLEN ROWE</b>  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><b>YES WW I</b>  |  | 16. SOCIAL SECURITY NO.<br><b>—</b>   |  |
| 17. INFORMANT<br><b>CLIN. RECORDS, VA HOSPITAL, FT HOWARD, MD.</b>  |  | Address   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <b>DIABETIC ACIDOSIS</b><br>DUE TO (b)<br>DUE TO (c)<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.                     |  |   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br>19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m.<br><b>19</b>   | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc)  | 20f. (City or town) (County) (State)                                       |
| 21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>12/7/67</b> , 19__ to <b>12/7/67</b> , 19__, that (I) (we) last saw the deceased alive on <b>12/7/67</b> , 19__, and that death occurred at <b>8:30 AM</b> from causes and on the date stated above. |  |   |  |
| 22a. SIGNATURE<br><i>John D. Talbert</i>  |  | 22b. DATE SIGNED<br><b>12/8/67</b>  |  |
| 22c. PHYSICIAN'S NAME (Type)<br><b>JOHN D. TALBERT, M. D.</b>   |  | 22d. ADDRESS<br><b>VAH FORT HOWARD, MARYLAND</b>  |  |
| 23a. BURIAL CREMATION REMOVAL (Specify)<br><b>BURIAL</b>  | 23b. DATE THEREOF<br><b>Dec 12, 1967</b>   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>SHILOH BAPTIST CEMETERY</b>  | 23d. LOCATION (City or Town) (County) (State)<br><b>GLOUCESTER CO. VA.</b> |
| 24. FUNERAL DIRECTOR<br><b>Herbert E. Nutter</b><br><b>3035 W. North Ave.</b>   |  | 25a. REC'D BY REGISTRAR<br><b>DEC 12 1967</b>   |  |
| 25b. REGISTRAR'S SIGNATURE<br><i>Charles Judge</i>  |  |   |  |



# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## CERTIFICATE OF DEATH

16702

10596

|   |                                      |  |  |
|---|--------------------------------------|--|--|
| 1 PLACE OF DEATH<br>a COUNTY <b>Baltimore</b> MARYLAND  |                                      | 2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Balto.</b>  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Catonsville</b>  |                                      | c. LENGTH OF STAY IN TB<br><b>2yr1mth17dys</b>   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Overlea</b> |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>Spring Grove State Hospital</b>  |                                      | d. STREET ADDRESS<br><b>608 Meadow Road</b>  | e. RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>        |
| 3 NAME OF DECEASED (Type or print)<br>First <b>Bloncie</b> Middle <b>ALEIN</b> Last <b>Teubner</b>  |                                      | 4. DATE OF DEATH<br>Month <b>December</b> Day <b>7</b> Year <b>1967</b>  |  |
| 5 SEX<br><b>Female</b>  | 6. COLOR OR RACE<br><b>White</b>     | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>   | 8. DATE OF BIRTH<br><b>2-16-04</b>   |
| 9 AGE (In years last birthday) <b>63</b> yrs  |                                      | 10. IF UNDER 1 Year<br>Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min <input type="checkbox"/>   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired)<br><b>Housewife</b>  |                                      | 10b. KIND OF BUSINESS OR INDUSTRY  | 11. BIRTHPLACE (County & State, or foreign country)<br><b>Maryland</b>                             |
| 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.</b>   |                                      | 13. FATHER'S NAME<br><b>Otto Wingate</b>   |  |
| 14. MOTHER'S MAIDEN NAME<br><b>Margaret</b>   |                                      | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><b>unknown</b>  |  |
| 16. SOCIAL SECURITY NO<br><b>212-03-1243</b>  |                                      | 17. INFORMANT<br><b>Records: Spring Grove State Hospital</b>   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Carcinoma of the face, histopathology</b><br>DUE TO <b>undetermined, with extensive invasion in-</b><br>(b) <b>to the skull and to the brain</b><br>DUE TO<br>(c)<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |                                      |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>25 years</b>  |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)   |                                      |  |  |
| 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |                                      | 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |
| 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)   |                                      | 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. <input type="checkbox"/> p.m. <input type="checkbox"/> 19  |  |
| 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>  |                                      | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |  |
| 20f. (City or town) (County) (State)  |                                      | 21. I certify that (this hospital) attended the deceased from <b>10-20-65</b> , 19 to <b>Dec. 7 1967</b> , that (we) last saw the deceased alive on <b>Dec. 7 1967</b> , and that death occurred at <b>8:00</b> M, from causes and on the date stated above. |  |
| 22a. SIGNATURE<br><i>Anthony J. Young</i>   |                                      | 22b. DATE SIGNED<br><b>12-8-67</b>   |  |
| 22c. PHYSICIAN'S NAME (Type)<br><b>Anthony J. Young, M.D.</b>   |                                      | 22d. ADDRESS<br><b>Spring Grove State Hospital<br/>Baltimore, Maryland 21228</b>   |  |
| 23a. BURIAL CREMATION REMOVAL (Specify)   | 23b. DATE THEREOF<br><b>12/11/67</b> | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Louisa Park</b>   | 23d. LOCATION (City or Town) (County) (State)<br><b>Balto Md</b>                                   |
| 24. FUNERAL DIRECTOR<br><b>Henry Sander &amp; Sons Inc. Balto Md</b>  |                                      | 25a. REC'D BY REGISTRAR<br><b>DEC 12 1967</b>  | 25b. REGISTRAR'S SIGNATURE<br><i>Charles Judge</i>   |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

16703

15697

|   |                                  |   |   |   |  |   |  |
|---|----------------------------------|---|---|---|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Baltimore</b> MARYLAND  |                                  |   |   | 2. USUAL RESIDENCE (Where deceased lived, if institut on Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>—</b> |  |   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Catonsville</b>  |                                  | c. LENGTH OF STAY IN lb<br><b>1yr8mth22dys</b>  |   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Baltimore</b>                                |  |   |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>SPRING GROVE STATE HOSPITAL</b>  |                                  |   |   | d. STREET ADDRESS<br><b>4225 Potter Street</b>  |  | e. RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>    |  |
| 3. NAME OF DECEASED<br>(Type or print)<br><b>Mae Agnes Theborge</b>   |                                  | First Middle Last   |   | 4. DATE OF DEATH<br><b>December 14 19 67</b>  |  | Month Day Year  |  |
| 5. SEX<br><b>female</b>   | 6. COLOR OR RACE<br><b>white</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>July 1, 1888</b> |   | 9. AGE (in years last birthday)<br><b>79</b> yrs | F UNDER 1 YEAR<br>Months Days Hours Mm.   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>housewife</b>   |                                  | 10b. KIND OF BUSINESS OR INDUSTRY   |   | 11. BIRTH PLACE (County & State, or foreign country)<br><b>Scotland</b>   |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U. S. A.</b>   |  |
| 13. FATHER'S NAME<br><b>James Higgins</b>   |                                  |   |   | 14. MOTHER'S MAIDEN NAME<br><b>Mary Marley</b>  |  |   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) (If yes give war or dates of service)  |                                  | 16. SOCIAL SECURITY NO.<br><b>223-03-9701D</b>  |   | 17. INFORMANT<br><b>Records: SPRING GROVE STATE HOSPITAL</b>  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY:<br><b>445X</b> IMMEDIATE CAUSE (a) <b>Pneumonia</b><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) DUE TO<br>(c)   |                                  |   |   |   |  | INTERVAL BETWEEN ONSET AND DEATH  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)   |                                  |   |   |   |  | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                                  | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)  |   |   |  |   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m. <b>19</b>  |                                  | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Not While <input type="checkbox"/><br>at work at work  |   | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |  | 20f. (City or town) (County) (State)  |  |
| 21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>March 22, 19 66</b> to <b>Dec. 14, 19 67</b> that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>Dec. 14 19 67</b> , and that death occurred at <b>5:28 P.M.</b> from causes and on the date stated above. |                                  |   |   |   |  |   |  |
| 22a. SIGNATURE<br><b>Michael W. Kilchenstein M.D.</b>   |                                  |   |   | 22b. DATE SIGNED<br><b>12-14-67</b>   |  | 22c. PHYSICIAN'S NAME (Type)<br><b>Michael W. Kilchenstein M. D.</b>                              |  |
| 22d. ADDRESS<br><b>SPRING GROVE STATE HOSPITAL<br/>Baltimore, Maryland 21228</b>  |                                  |   |   |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>  |                                  | 23b. DATE THEREOF<br><b>12-19-1967</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Loudon Park Cemetery</b>   |  | 23d. LOCATION (City or Town) (County) (State)<br><b>Baltimore, Maryland</b>                       |  |
| 24. FUNERAL DIRECTOR<br><b>Howard H. Hubbard, 4107 Wilkens Avenue 21229</b>   |                                  |   |   | 25a. REC'D BY REGISTRAR<br><b>DATE DEC 18 1967</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><i>J. Charles Judge</i>   |  |





**TICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH** 16698

FOR STATE  
HEALTH DEPT.

**TO DEPUTY CHIEF MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any of the information is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

V5. AISME  
5M 9 60

|  |  |   |  |
|--|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>BALTIMORE</u><br>b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>DUNDALK</u><br>c. LENGTH OF STAY IN 1b <u>10 YRS.</u><br>d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>1943 DUNDALK AVE</u>   |  | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)<br>a. STATE <u>MD.</u><br>b. COUNTY <u>BALTIMORE</u><br>c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>DUNDALK</u><br>d. STREET ADDRESS <u>1943 DUNDALK AVE.</u> |  |
| 3. NAME OF DECEASED<br>(Type or print) <u>HENRY SYLVESTER THOMAS</u><br>First Middle Last<br>4. DATE OF DEATH <u>28 DEC.</u> 19 <u>67</u><br>Month Day Year  |  | 5. SEX <u>MALE</u><br>6. COLOR OR RACE <u>CAUCASIAN</u><br>7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FOREMAN</u><br>13. FATHER'S NAME <u>JOSEPH S. THOMAS</u>  |  | 10b. KIND OF BUSINESS OR INDUSTRY <u>TEXTILE INDUSTRY</u><br>11. BIRTHPLACE (State or foreign country) <u>N. CAROLINA</u><br>12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? <u>NO</u><br>(Yes, no, or unknown) (If yes, give year or dates of service)   |  | 16. SOCIAL SECURITY NO. <u>442-01-3244</u><br>17. INFORMANT <u>PAUL S. THOMAS</u><br>Address <u>1817 SOUTH BEND DR. ALVIN, TEXAS</u>  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>CORONARY OCCLUSION</u><br>+ 201 DUE TO (b) <u>A-S-C-V-DISEASE</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) <u>Obesity</u>  |  | 19. WAS AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO  |  |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part I. of item 18.)  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m. <u>19</u>   |  | 20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work  |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |  | 20f. (City or town) (County) (State)  |  |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |  |   |  |
| ACTUAL SIGNATURE <u>M.B. Davis</u>   |  | CHIEF MEDICAL EXAMINER <input type="checkbox"/>   |  |
| EXAMINER'S NAME (Type) <u>M.B. DAVIS, M.D.</u>   |  | DATE SIGNED <u>6:00 AM</u>  |  |
| 22b. DATE THEREOF <u>1/4/1968</u>  |  | 22c. NAME OF CEMETERY OR CREMATORY <u>OAKWOOD</u>   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>  |  | 22d. LOCATION (City, town, or country) (State) <u>CONCORD, N.C.</u>   |  |
| 23. FUNERAL DIRECTOR <u>W. Brock Bradley, Dundalk, Md.</u>   |  | 24a. REC'D BY REGISTRAR <u>JAN 2 1968</u>   |  |
|  |  | 24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>   |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove copy papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

| MARYLAND STATE DEPARTMENT OF HEALTH  |                                  |  |  | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |   |  |
|--|----------------------------------|--|--|--|--|---|--|
| CERTIFICATE OF DEATH   |                                  |  |  | 16699  |  |   |  |
| 1 PLACE OF DEATH<br>a. COUNTY <b>BALTIMORE</b><br>MARYLAND   |                                  | 2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <b>MARYLAND</b><br>b. COUNTY <b>-</b> |  |  |  |   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>FORT HOWARD</b>   |                                  | c. LENGTH OF STAY IN 1b<br><b>52 DAYS</b>  |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>BALTIMORE - 21223</b>                       |  |   |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>VETERANS ADMINISTRATION HOSPITAL</b>  |                                  |  |  | d. STREET ADDRESS<br><b>954 W. SARATOGA STREET</b>   |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 3. NAME OF DECEASED<br>(Type or print)<br><b>CHARLES HENRY TILGHMAN</b>  |                                  | First Middle Last  |  | 4. DATE OF DEATH<br>Month Day Year<br><b>DECEMBER 18 19 67</b>   |  |   |  |
| 5. SEX<br><b>MALE</b>  | 6. COLOR OR RACE<br><b>NEGRO</b> | 7. MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/>   | 8. NEVER MARRIED <input type="checkbox"/><br>DIVORCED <input type="checkbox"/> | 9. AGE (In years last birthday)<br><b>57 yrs</b>   |  | 10. IF UNDER 1 YEAR<br>Months Days Hours Min  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>STEVEDORE</b>  |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>SHIPPING</b>   |  | 11. BIRTHPLACE (County & State, or foreign country)<br><b>BALTIMORE, MARYLAND</b>  |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  |
| 13. FATHER'S NAME<br><b>CHARLES H. TILGHMAN</b>  |                                  |  |  | 14. MOTHER'S MAIDEN NAME<br><b>IDA M. WILLIAMS</b>   |  |   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) (If yes give war or dates of service)<br><b>YES WW II</b>   |                                  | 16. SOCIAL SECURITY NO.<br><b>214 12 22 52</b>   |  | 17. INFORMANT<br>Address<br><b>CLIN. RECORDS, VA HOSPITAL, FT HOWARD, MD.</b>  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY<br><b>443X</b><br>IMMEDIATE CAUSE (a)<br>DUE TO<br><b>BRAIN STEM HEMORRHAGE</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(b)<br>DUE TO<br><b>HYPERTENSIVE CARDIOVASCULAR DISEASE</b><br>(c) |                                  |  |  |  |  | INTERVAL BETWEEN ONSET AND DEATH  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br><b>BRONCHOPNEUMONIA</b>   |                                  |  |  |  |  | 19. WAS AUTOPSY PERFORMED?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, NOTIFY MEDICAL EXAMINER)   |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)  |  |  |  |   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m.<br><b>19</b>  |                                  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>                              |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |  | 20f. (City or town) (County) (State)  |  |
| 21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>10/27/67</b> 19 to <b>12/18/67</b> 19, that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>12/18/67</b> 19, and that death occurred at <b>7:30P</b> M, from causes and on the date stated above.                              |                                  |  |  |  |  |   |  |
| 22a. SIGNATURE<br><i>John D. Talbert</i>   |                                  |  |  | M.D. ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/> |  | 22b. DATE SIGNED<br><b>12/19/67</b>   |  |
| 22c. PHYSICIAN'S NAME (Type)<br><b>JOHN D. TALBERT, M. D.</b>  |                                  |  |  | 22d. ADDRESS<br><b>VAH FORT HOWARD, MARYLAND</b>   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>   |                                  | 23b. DATE THEREOF<br><b>12-22-1967</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>BALTIMORE NATIONAL</b>  |  | 23d. LOCATION (City or Town) (County) (State)<br><b>BALTIMORE, MARYLAND</b>                       |  |
| 24. FUNERAL DIRECTOR<br><i>Chas O. Wilson</i>  |                                  |  |  | 25a. REC'D BY REG STRAR<br>DATE <b>DEC 20 1967</b>   |  | 25b. REG STRAR'S SIGNATURE<br><i>Charles Judge</i>  |  |
| WILSON FUNERAL HOME<br>ORLEANS ST. BALTIMORE, MD.  |                                  |  |  |  |  |   |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

16700

|   |   |   |   |
|---|---|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Baltimore</b> MARYLAND  |   | 2. USUAL RESIDENCE (Where deceased lived, if not in residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>✓</b>                              |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Fort Howard</b>  |   | c. LENGTH OF STAY IN 'b<br><b>10 days</b>   |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>Veterans Administration Hospital</b>   |   | e. STREET ADDRESS<br><b>1732 Milton Avenue</b>  |   |
| 3. NAME OF DECEASED<br>(Type or print) <b>FRANK</b> First Middle Last <b>TOLIVER</b>  |   | 4. DATE OF DEATH<br>Month <b>December</b> Day <b>20</b> Year <b>1967</b>  |   |
| 5. SEX<br><b>Male</b>   | 6. COLOR OR RACE<br><b>Negro</b>  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>Dec. 25, 1916</b>  |
| 9. AGE (In years last birthday) <b>51</b> yrs   |   | 10. IF UNDER 1 YEAR Months Days Hours Min   |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Crane Operator</b>  |   | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Snipyard</b>  |   |
| 11. BIRTHPLACE (County & State or foreign country)<br><b>Fairfield, S.C.</b>  |   | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |   |
| 13. FATHER'S NAME<br><b>Robert Toliver</b>  |   | 14. MOTHER'S MAIDEN NAME<br><b>Adeline Brown</b>  |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><b>Yes WW-II</b>  |   | 16. SOCIAL SECURITY NO<br><b>249 16 91 71</b>   |   |
| 17. INFORMANT<br><b>Clinical Rcds, VA Hospital, Fort Howard, Md.</b>  |   | Address   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>UREMIA</b><br>DUE TO (b) <b>—</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) <b>ARTERIOIAR NEPHROSCLEROSIS</b>                        |   |   | INTERVAL BETWEEN CAUSE AND DEATH<br><b>UNKNOWN</b>  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |   |   | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |   | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)  |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m. <b>19</b>  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  | 20f. (City or town) (County) (State)  |
| 21. I certify that <input checked="" type="checkbox"/> (this hospita) attended the deceased from <b>Dec. 18, 1967</b> to <b>Dec. 20, 1967</b> that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>Dec. 20, 1967</b> , and that death occurred at <b>1 P.M.</b> from causes and on the date stated above |   |   |   |
| 22a. SIGNATURE<br><b>Neilson Neilson</b>  |   | 22b. DATE SIGNED<br><b>12/28/67</b>   |   |
| 22c. PHYSICIAN'S NAME (Type)<br><b>NEILSON, NEILSON, M.D.</b>   |   | 22d. ADDRESS<br><b>VA Hospital, Fort Howard, Md.</b>  |   |
| 23a. BURIAL CREMATION, REMOVAL (Specify)<br><b>Removal</b>  | 23b. DATE OF REOF<br><b>12-29-67</b>  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Mt. Pilgrim Cemetery</b>   | 23d. LOCATION (City or Town) (County) (State)<br><b>Chester, South Carolina</b>                   |
| 24. FUNERAL DIRECTOR<br><b>COLLICK FUNERAL HOME</b>   |   | 25a. REC'D BY REG-STRAR<br><b>2431 E Oliver St<br/>Baltimore, Md.</b>   | 25b. REGISTRAR'S SIGNATURE<br><b>Charles J. [Signature]</b>                                       |
| DATE <b>JAN 3 1968</b>  |   |   |   |

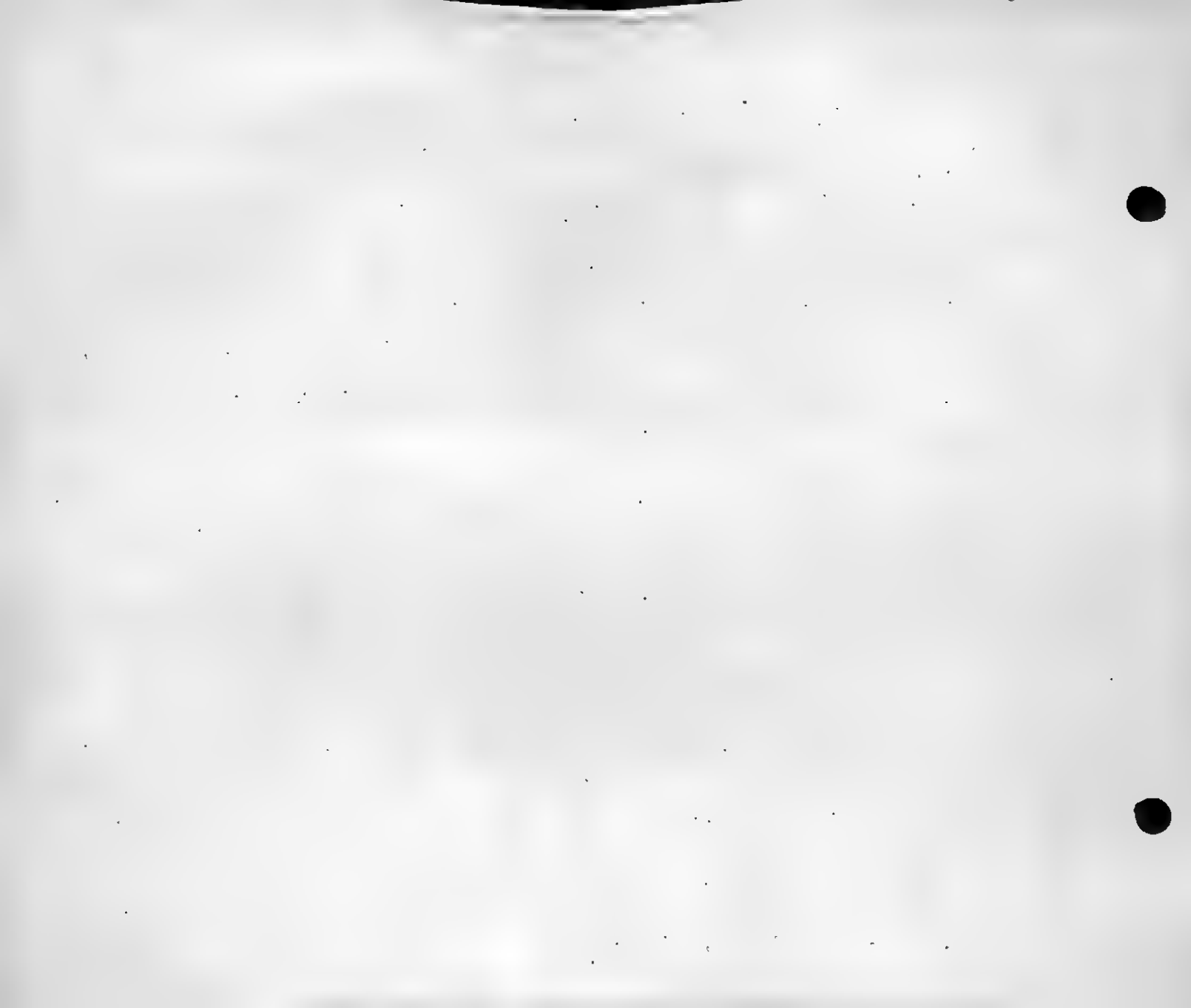


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. (Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.)

**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**  
**CERTIFICATE OF DEATH**

|  |   |  |  |
|--|---|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Baltimore County</u> MARYLAND  |   | 2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission)<br>a. STATE <u>Pennsylvania</u> b. COUNTY <u>Allentown</u>         |  |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Towson - Baltimore</u>   |   | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Allentown</u>  |  |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Greater Baltimore Medical Center</u>   |   | d. STREET ADDRESS <u>1444 Hamilton street</u>  |  |
| 3. NAME OF DECEASED (Type or print) <u>Samuel William Traylor, Jr.</u>   |   | 4. DATE OF DEATH<br>Month <u>December</u> Day <u>6</u> Year <u>1967</u>  |  |
| 5. SEX <u>Male</u>   | 6. COLOR OR RACE <u>White</u>   | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>3-24-96</u>  |
| 9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>retired</u>  |   | 9b. KIND OF BUSINESS OR INDUSTRY   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>retired</u>   |   | 10b. KIND OF BUSINESS OR INDUSTRY  |  |
| 11. BIRTHPLACE (County & State, or foreign country) <u>Denver, Colorado</u>  |   | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u>  |  |
| 13. FATHER'S NAME <u>Samuel William Traylor, Sr.</u>   |   | 14. MOTHER'S MAIDEN NAME <u>Belle Binkley</u>  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>unknown</u>   |   | 16. SOCIAL SECURITY NO. <u>194-07-9798</u>   |  |
| 17. INFORMANT  |   | Address  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Renal shut down</u><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <u>several cardiac arrests + myocardial infarct</u><br>DUE TO<br>(c) <u>post op laryngectomy for cancer of larynx</u> |   |  | INTERVAL BETWEEN ONSET AND DEATH<br><u>2 days</u><br><u>2 weeks</u>                    |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |   |  | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a.m. p.m. <u>19</u>  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   | 20f. (City or town) (County) (State)   |
| 21. I certify that (I) (this hospital) attended the deceased from <u>11/2</u> , 19 <u>67</u> , to <u>12/6</u> , 19 <u>67</u> , that (II) (we) last saw the deceased alive on <u>12/6</u> , 19 <u>67</u> , and that death occurred at <u>9 P.</u> M., from the causes and on the date stated above.   |   |  |  |
| 22a. SIGNATURE <u>M. E. Kelle Commiser</u>   |   | 22b. DATE SIGNED <u>12/6/67</u>  |  |
| 22c. PHYSICIAN'S NAME (Type)   |   | 22d. ADDRESS   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>  |   | 23b. DATE THEREOF <u>12-9-67</u>   |  |
| 23c. NAME OF CEMETERY OR CREMATORY <u>Grandview Cemetery</u>   |   | 23d. LOCATION (City, town or county) (State) <u>Allentown, Penna.</u>  |  |
| 24. FUNERAL DIRECTOR <u>Wm. Cook-Brooks Towson,</u>  |   | 25a. REC'D BY REGISTRAR <u>11/11/1967</u>  |  |
| ADDRESS <u>1050 York Road Towson, Maryland 21204</u>   |   | 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>  |  |





# FOR STATE HEALTH DEPT.

THIS DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal and in any event within 72 hours after death.

VR A15ME (5)  
6M 1/67

16706

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

16702

|   |                                   |  |   |   |   |   |  |
|---|-----------------------------------|--|---|---|---|---|--|
| 1 PLACE OF DEATH<br>a COUNTY <u>Baltimore</u> MARYLAND  |                                   |  |   | 2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission)<br>a STATE <u>MD.</u> b COUNTY <u>Pat.</u> |   |   |  |
| b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Towson</u>  |                                   |  |   | c LENGTH OF STAY IN TB  |   |   |  |
| d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><u>St. Joseph's Hospital</u>   |                                   |  |   | d STREET ADDRESS<br><u>Big Falls Rd.</u>  |   |   |  |
| 3 NAME OF DECEASED<br>(Type or print) <u>ANNIE ADURA TURNER</u>   |                                   |  |   | 4 DATE OF DEATH<br>Month <u>12</u> Day <u>4</u> Year <u>1967</u>  |   |   |  |
| 5 SEX<br><u>FEMALE</u>  | 6 COLOR OR RACE<br><u>NEGROID</u> | 7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>W DOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8 DATE OF BIRTH<br><u>9-15-08</u>   | 9 AGE (in years, last birthday) yrs <u>59</u>   | 10 UNDER 1 YEAR<br>Months <u>4</u> Days <u>19</u> Hours <u>67</u> Min |   |  |
| 10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)  |                                   | 10b KIND OF BUSINESS OR INDUSTRY   |   | 11 BIRTHPLACE (State or foreign country)<br><u>VA.</u>  |   | 12 CITIZEN OF WHAT COUNTRY?<br><u>U.S.A.</u>                        |  |
| 13 FATHER'S NAME  |                                   |  |   | 14 MOTHER'S MAIDEN NAME<br><u>ALFREDA JENKINS</u>   |   |   |  |
| 15 WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) (If yes give war or dates of service)<br><u>No</u>  |                                   | 16 SOCIAL SECURITY NO<br><u>220-24-8587</u>  |   | 17 INFORMANT<br><u>ROBERT TURNER</u>  |   | Address<br><u>SAME</u>  |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>4201 Coronary Occlusion</u><br>DUE TO (b) <u>Hypertensive Cardiovascular</u><br>DUE TO (c) <u>Vascular Disease</u>   |                                   |  |   |   |   | INTERVAL BETWEEN ONSET AND DEATH<br><u>Sudden</u><br><u>5 yrs</u>   |  |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)   |                                   |  |   |   |   |   |  |
| 20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |                                   |  | 20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of item 18)  |   |   |   |  |
| 20c TIME OF INJURY Month, Day, Year<br>Hour a.m. <u>19</u> p.m.   |                                   |  | 20d INJURY OCCURRED<br>While <input type="checkbox"/> Not While <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/> |   | 20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) |   |  |
| 20f (City or town)  |                                   |  | (County)  |   | (State)   |   |  |
| 21 I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> |                                   |  |   |   |   |   |  |
| ACTUAL SIGNATURE<br><u>Charles F. O'Donnell</u> M.D.  |                                   |  | 22. DATE SIGNED<br><u>12/4/67</u>   |   | 22. DATE SIGNED   |   |  |
| EXAMINER'S NAME (Type) <u>Charles F. O'Donnell, M.D.</u>  |                                   |  | Address (Street, city, town, or county)   |   |   |   |  |
| 23a BURIAL CREMATION REMOVAL Specify <u>Burial</u>  |                                   | 23b DATE THEREOF<br><u>12/8/67</u>   |   | 23c NAME OF CEMETERY OR CREMATORY<br><u>Arbutus Mem. Pk.</u>  |   | 23d LOCATION (City or Town) (County) (State)<br><u>Arbutus, Md.</u> |  |
| 24 FUNERAL DIRECTOR<br><u>Kelson Funeral Home</u>   |                                   |  | ADDRESS<br><u>1348 Calhoun St.</u>  |   | 25a REC'D BY REGISTRAR<br>DATE <u>DEC 5 1967</u>                      |   |  |
|   |                                   |  |   |   | 25b REGISTRAR'S SIGNATURE<br><u>Charles Judge</u>                     |   |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2. Page 1 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 and 2  
1 and 2

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16701

CERTIFICATE OF DEATH

16703

|   |  |   |   |
|---|--|---|---|
| 1 PLACE OF DEATH<br>a COUNTY<br><b>Baltimore</b><br>b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Towson</b><br>c LENGTH OF STAY IN 1b<br><b>16701</b>  |  | 2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission)<br>a STATE<br><b>Maryland</b><br>b COUNTY<br><b>Baltimore 21206</b>    |   |
| d NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>St. Joseph Hospital</b>  |  | d STREET ADDRESS<br><b>7 Fuller Ave.</b><br>e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                   |   |
| 3 NAME OF DECEASED (Type or print)<br>First Middle Last<br><b>Stella B. TURNER</b>  |  | 4. DATE OF DEATH<br>Month Day Year<br><b>December 1, 19 67</b>  |   |
| 5 SEX<br><b>Female</b>  | 6 COLOR OR RACE<br><b>White</b>  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8 DATE OF BIRTH<br><b>September 19, 1897</b><br>9 AGE (In years last birthday) <b>70</b> yrs                          |
| 10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Homemaker</b>  |  | 10b KIND OF BUSINESS OR INDUSTRY<br><b>Housewife</b>  | 11 BIRTHPLACE (County & State, or foreign country)<br><b>Maryland</b><br>12 CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b> |
| 13. FATHER'S NAME<br><b>Unknown Buettner</b>  |  | 14. MOTHER'S MAIDEN NAME<br><b>Unknown</b>  |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><b>No</b>  |  | 16. SOCIAL SECURITY NO.<br><b>218-14-0856A</b>  |   |
| 17 INFORMANT<br><b>Mr James E. Turner</b>   |  | Address<br><b>7 Fuller Avenue 21206</b>   |   |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I: DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Metastatic carcinoma of the lung</b><br>DUE TO (b) <b>Primary in the right breast</b><br>DUE TO (c) <b>170X</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.   |  |   |   |
| PART II: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)<br>19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  |   |   |
| 20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m. <b>19</b>  | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Not While <input type="checkbox"/><br>at work at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  | 20f. (City or town) (County) (State)  |
| 21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>11/29/</b> , 19 <b>67</b> , to <b>12/1/</b> , 1967, that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>12/1/</b> , 19 <b>67</b> and that death occurred at <b>2:52 M.</b> from causes and on the date stated above. |  |   |   |
| 22a SIGNATURE<br><b>Inez Cilliani</b>   |  | 22b. DATE SIGNED<br><b>12/2/1967</b>  |   |
| 22c. PHYSICIAN'S NAME (Type)<br><b>Inez Cilliani, M. D.</b>   |  | 22d ADDRESS<br><b>7620 York Rd., Towson, Md. 21204</b>  |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  | 23b. DATE THEREOF<br><b>12-4-1967</b>  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Parkwood Cemetery</b>  | 23d. LOCATION (City or Town) (County) (State)<br><b>Baltimore Co. Md.</b>   |
| 24. FUNERAL DIRECTOR<br><b>Lassahn Funeral Home 7401 Belair Rd</b>  |  | 25a. REC'D BY REGISTRAR<br><b>DEC 4 1967</b>  |   |
| ADDRESS<br><b>236</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>J Charles Joyce</b>  |   |



# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (S)  
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

16710

16704

|   |                                      |  |   |
|---|--------------------------------------|--|---|
| 1 PLACE OF DEATH<br>a. COUNTY <b>Baltimore</b> MARYLAND   |                                      | 2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>St. Mary's</b>                                   |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Owings Mills</b>   |                                      | c. LENGTH OF STAY IN 1b<br><b>3 1/2 yrs.</b>   |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>Rosewood State Hospital</b>  |                                      | e. STREET ADDRESS<br><b>-</b>  |   |
| 3. NAME OF DECEASED (Type or print)<br><b>Deborah Mae VALLANDINGHAM</b>   |                                      | 4. DATE OF DEATH<br>Month <b>12</b> Day <b>12</b> Year <b>19 67</b>  |   |
| 5. SEX<br><b>Female</b>   | 6. COLOR OR RACE<br><b>White</b>     | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>                       | 8. DATE OF BIRTH<br><b>1-4-57</b>                                   |
| 9. AGE (In years and months)<br><b>10</b> yrs   |                                      | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Dependent</b>   |   |
| 11. BIRTHPLACE (State or foreign country)<br><b>St. Mary's Co., Md.</b>   |                                      | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |   |
| 13. FATHER'S NAME<br><b>William Laurence Vallandingham</b>  |                                      | 14. MOTHER'S MAIDEN NAME<br><b>Mary Helen Thomas</b>   |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><b>no</b>  |                                      | 16. SOCIAL SECURITY NO.<br><b>none</b>   |   |
| 17. INFORMANT<br><b>Rosewood Records, Owings Mills, Maryland</b>  |                                      | Address  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Tracheal Bronchial Obstruction, mucous plug</b><br>500 X DUE TO (b) <b>Bronchial Pneumonia, right lung</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first DUE TO (c) <b>Acute Hemorrhagic Bronchitis</b>  |                                      | INTERVAL BETWEEN ONSET AND DEATH<br><b>Terminal</b><br><b>10 days</b><br><b>10 days</b>  |   |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br><b>Institutionalization due to severe mental retardation.</b>   |                                      | 19. WAS AUTOPSY PERFORMED?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |   |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.   |                                      | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)   |   |
| 20c. TIME OF INJURY Month, Day, Year<br><b>12 noon 12/12 19 67</b>  |                                      | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/> |   |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office, etc.)<br><b>Spas. 3 - Rosewood St. Hosp. Owings Mills, Balto., Md.</b>   |                                      | 20f. (City or town) (County) (State)   |   |
| 21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> |                                      |  |   |
| ACTUAL SIGNATURE<br><b>D.D. Caples</b>  |                                      | 22. DATE SIGNED<br><b>12/13/67</b>   |   |
| EXAMINER'S NAME (Type)<br><b>D.D. Caples, M.D.</b>  |                                      | Address (Street, city, town, or county)<br><b>Reisterstown, Md.</b>  |   |
| 23a. BURIAL CREMATION, REMOVAL (Specify)<br><b>Burial</b>   | 23b. DATE THEREOF<br><b>12/15/67</b> | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Sacred Heart</b>  | 23d. LOCATION (City or Town) (County) (State)<br><b>Bushwood Md</b> |
| 24. FUNERAL DIRECTOR<br><b>W. Clarke Mattingley</b>   |                                      | 25a. RECD BY REGISTRAR<br><b>DEC 15 1967</b>   |   |
| ADDRESS<br><b>Reisterstown Md</b>   |                                      | 25b. REGISTRAR'S SIGNATURE<br><b>John A. Jones</b>   |   |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, and in any event within 72 hours after death, should be filed with the State Dept. of Health prior to burial, cremation, or removal.

VR A15 (4)  
25M 1/67

| MARYLAND STATE DEPARTMENT OF HEALTH  |  |   |   |
|--|--|---|---|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |   |   |
| 16711  |  | 16705   |   |
| CERTIFICATE OF DEATH   |  |   |   |
| 1. PLACE OF DEATH<br>a. COUNTY <b>Baltimore</b> MARYLAND   |  | 2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission)<br>a. STATE <b>Md.</b> b. COUNTY <b>Baltimore</b>                     |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Towson</b>  |  | c. LENGTH OF STAY IN 1b<br><b>Rodgers Forge</b>   |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>Towson Convalescent Home</b><br><b>301 Chesapeake Ave</b>   |  | d. STREET ADDRESS<br><b>214 Regester Ave</b>  |   |
| 3. NAME OF DECEASED<br>(Type or print)<br><b>Sarah E Vickers</b>   |  | 4. DATE OF DEATH<br>Month <b>12</b> Day <b>22</b> Year <b>1967</b>  |   |
| 5. SEX<br><b>Female</b>  | 6. COLOR OR RACE<br><b>White</b>   | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>Nov. 14, 1883</b><br>9. AGE (in years lost birthday) <b>84 yrs</b> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Homemaker</b>  |  | 10b. KIND OF BUSINESS OR INDUSTRY   |   |
| 11. BIRTHPLACE (County & State, or foreign country)<br><b>Kent, Co. Md.</b>  |  | 12. CITIZEN OF WHAT COUNTRY?  |   |
| 13. FATHER'S NAME<br><b>Benjamin F. Morris</b>   |  | 14. MOTHER'S MAIDEN NAME<br><b>Mary Jane Gooding</b>  |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) (If yes give war or dates of service)   |  | 16. SOCIAL SECURITY NO  |   |
| 17. INFORMANT<br><b>Mrs Margaret Huegelmeyer</b>   |  | Address<br><b>214 Regester Ave</b>  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Congestive heart failure</b><br>DUE TO (b) <b>Arteriosclerotic H.D</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) |  |   | INTERVAL BETWEEN ONSET AND DEATH  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)   |  | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)  |   |
| 20c. TIME OF INJURY Month Day Year<br>Hour a.m. p.m. <b>19</b>   | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Not While <input type="checkbox"/><br>at work at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc)   | 20f. (City or town) (County) (State)  |
| 21. I certify that (I) (this hospital) attended the deceased from <b>August, 1961</b> , to <b>12-22, 1967</b> that (I) (we) last saw the deceased alive on <b>12-18-1967</b> , and that death occurred at <b>12:00 PM</b> , from causes and on the date stated above.  |  |   |   |
| 22a. SIGNATURE<br><b>K A Petrucci</b>  |  | 22b. DATE SIGNED<br><b>12-24-67</b>   |   |
| 22c. PHYSICIAN'S NAME (Type)<br><b>K A Petrucci</b>  |  | 22d. ADDRESS<br><b>100 W. University Pkwy 21210</b>   |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   | 23b. DATE THEREOF<br><b>12/26/1967</b>   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Loudon Park Cemetery</b>   | 23d. LOCATION (City or Town) (County) (State)   |
| 24. FUNERAL DIRECTOR<br><b>Mitchell-Wiedefeld Home</b>   |  | 25a. REC'D BY REG STRAR<br>DATE <b>DEC 29 1967</b>  |   |
| ADDRESS<br><b>6500 York Rd.</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>  |   |





CERTIFICATE OF DEATH

16706

16712

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

|   |  |  |  |
|---|--|--|--|
| 1 PLACE OF DEATH<br>a. COUNTY <b>BALTIMORE</b> MARYLAND   |  | 2. USUAL RESIDENCE (Where deceased lived, if institut on Residence before admp.ssan)<br>a STATE <b>MARYLAND</b> b COUNTY                                   |  |
| b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>PIKESVILLE</b>  |  | c LENGTH OF STAY IN 1b<br><b>BALTIMORE</b>   |  |
| d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>MILFORD MANOR NURSING HOME, MILFORD MILL RD 7000 FIELDCREST ROAD #21215</b>   |  | e IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |
| 3 NAME OF DECEASED<br>(Type or print)<br>First <b>GERTRUDE</b> Middle <b>VINE</b> Last <b>VINE</b>  |  | 4 DATE OF DEATH<br>Month <b>DECEMBER</b> Day <b>3</b> Year <b>19 67</b>  |  |
| 5 SEX<br><b>FEMALE</b>  | 6 COLOR OR RACE<br><b>WHITE</b>  | 7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>78</b> yrs.   |
| 9a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>HOUSEWIFE</b>   |  | 9b. KIND OF BUSINESS OR INDUSTRY<br><b>AT HOME</b>   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>HOUSEWIFE</b>   |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>AT HOME</b>  |  |
| 11 BIRTHPLACE (County & State, or foreign country)<br><b>RUSSIA</b>   |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  |
| 13 FATHER'S NAME<br><b>DAVITZ</b>   |  | 14. MOTHER'S MAIDEN NAME<br><b>EDITH</b>   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><b>NO</b>  |  | 16 SOCIAL SECURITY NO<br><b>NO</b>   |  |
| 17 INFORMANT<br><b>MRS. EDITH FINE, 5805 CROSS COUNTRY BLVD. #9</b>   |  | Address <b>APT. C</b>  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY.<br><b>1992 IMMEDIATE CAUSE (a) Sarcocoma with metastasis</b><br>DUE TO<br>(b)<br>(c)   |  |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>1 yr +</b>                          |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)   |  |  |  |
| 20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)<br><b>no</b>  |  | 20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of item 18)   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m. <b>19</b>  | 20d INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  | 20f (City or town) (County) (State)  |
| 21. I certify that (I) (this hospital) attended the deceased from <b>1/6, 1963</b> to <b>12/3, 1967</b> that (I) (we) last saw the deceased alive on <b>12/3 1967</b> , and that death occurred at <b>10:30</b> M, from causes and on the date stated above |  |  |  |
| 22a. SIGNATURE<br><b>Maurice Feldman</b>  |  | 22b DATE SIGNED<br><b>12/4/67</b>  |  |
| 22c PHYSICIAN'S NAME (Type)<br><b>DR. MAURICE FELDMAN</b>   |  | 22d ADDRESS<br><b>6610 CROSS COUNTRY BLVD.</b>   |  |
| 23a BURIAL, CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>   | 23b DATE THEREOF<br><b>12-5-67</b>   | 23c NAME OF CEMETERY OR CREMATORY<br><b>BETH EL MEMORIAL PARK</b>  | 23d LOCATION (City or Town) (County) (State)<br><b>BALTIMORE, MARYLAND</b> |
| 24. FUNERAL DIRECTOR<br><b>SOL LEVINSON &amp; BROS. INC., 6010 REISTERSTOWN ROAD</b>  |  | 25a. REGD BY REG. STRAR<br><b>DEC 8 1967</b>   | 25b REG STRAR'S SIGNATURE<br><b>Charles Judge</b>                          |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

|   |  |   |  |
|---|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Baltimore County</u><br><u>Baltimore</u> MARYLAND   |  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <u>Maryland</u> b. COUNTY <u>Balt. City</u>               |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Mount Wilson</u>   |  | c. LENGTH OF STAY IN TB   |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><u>Mount Wilson State Hospital</u>  |  | e. STREET ADDRESS <u>701 E. Baltimore St.</u><br><u>16707</u>   |  |
| 3. NAME OF DECEASED<br>(Type or print) <u>Leonard Morthy Von Schroeder</u>  |  | 4. DATE OF DEATH<br>Month <u>December</u> Day <u>12</u> Year <u>1967</u>  |  |
| 5. SEX<br><u>M</u>  | 6. COLOR OR RACE<br><u>W</u>   | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><u>August 11, 1900</u>                             |
| 9. AGE (In years last birthday)<br><u>67</u> yrs.   |  | IF UNDER 1 YEAR <input checked="" type="checkbox"/> IF UNDER 24 HRS <input type="checkbox"/><br>Months Days Hours Min.                                      |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Laborer</u>   |  | 10b. KIND OF BUSINESS OR INDUSTRY   |  |
| 11. BIRTHPLACE (County & State, or foreign country)<br><u>Maryland</u>  |  | 12. CITIZEN OF WHAT COUNTRY?<br><u>U.S.A.</u>   |  |
| 13. FATHER'S NAME<br><u>George Von Schroeder</u>  |  | 14. MOTHER'S MAIDEN NAME<br><u>Anna Poffemberger</u>  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><u>Unknown</u>   |  | 16. SOCIAL SECURITY NO.<br><u>183-12-7512</u>   |  |
| 17. INFORMANT<br><u>Records, Mt. Wilson State Hospital</u>  |  | Address   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Heart failure</u><br>DUE TO<br>(b) <u>Cor Pulmonale</u><br>DUE TO<br>(c) <u>Pulmonary Emphysema</u>   |  | INTERVA. BETWEEN ONSET AND DEATH<br><u>Two years</u>  |  |
| PART I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br><u>XXXXXX Far Advanced Pulmonary Tuberculosis</u>  |  | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of item 18)   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. _____<br>p.m. <u>19</u>   | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Not While <input type="checkbox"/><br>at work at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  | 20f. (City or town) (County) (State)                                   |
| 21. I certify that (I) (this hospital) attended the deceased from <u>September 21, 1967</u> to <u>December 12, 1967</u> , that (I) (we) last saw the deceased alive on <u>December 12, 1967</u> , and that death occurred at <u>5:00 PM</u> , from causes and on the date stated above. |  |   |  |
| 22a. SIGNATURE<br><u>Wm. Newcomer</u>   |  | 22b. DATE SIGNED  |  |
| 22c. PHYSICIAN'S NAME (Type)<br><u>Wm. Newcomer, M.D., Superintendent</u>   |  | 22d. ADDRESS<br><u>Mount Wilson, Maryland</u>   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)   | 23b. DATE THEREOF<br><u>12-18-67</u>   | 23c. NAME OF CEMETERY OR CREMATORY<br><u>St. Paul's M.D. School</u>   | 23d. LOCATION (City or town) (County) (State)<br><u>Baltimore, Md.</u> |
| 24. FUNERAL DIRECTOR<br><u>St. Paul's Funeral Home</u>  |  | 25a. REC'D BY REGISTRAR<br><u>DEC 20 1967</u>   |  |
| 25b. REGISTRAR'S SIGNATURE<br><u>William J. Judge</u>   |  |   |  |



1  
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.  
Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
16714  
CERTIFICATE OF DEATH 15708

|   |  |   |  |   |                                  |
|---|--|---|--|---|----------------------------------|
| 1. PLACE OF DEATH<br>a. COUNTY <b>BALTIMORE</b><br>b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>TOWSON</b><br>c. LENGTH OF STAY IN 1b<br>d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>604 W. JOPPA ROAD</b>                 |  | 2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission)<br>a. STATE <b>MARYLAND</b> b. COUNTY <b>BALTO.</b><br>c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>TOWSON</b><br>d. STREET ADDRESS <b>604 W. JOPPA ROAD</b>               |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                  |
| 3. NAME OF DECEASED<br>(Type or print) <b>John T. Waldhauser Jr.</b>  |  | 4. DATE OF DEATH <b>DEC. 28 19 67</b>   |  | 5. SEX <b>M</b>   |                                  |
| 6. COLOR OR RACE <b>W</b>   |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>  |  | 8. DATE OF BIRTH <b>MAY 30, 1902</b>  |                                  |
| 9. AGE (in years last birthday) <b>65</b> yrs.  |  | 10. BIRTHPLACE (County & State, or foreign country) <b>NEW YORK</b>   |  | 11. CITIZEN OF WHAT COUNTRY? <b>USA</b>   |                                  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>LAWYER - RETIRED</b>   |  | 10b. KIND OF BUSINESS OR INDUSTRY <b>LAW</b>  |  | 12. CITIZEN OF WHAT COUNTRY? <b>USA</b>   |                                  |
| 13. FATHER'S NAME <b>JOHN T. WALDHAUSER SR.</b>   |  | 14. MOTHER'S MAIDEN NAME <b>MARGARET BOWLING</b>  |  |   |                                  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>   |  | 16. SOCIAL SECURITY NO. <b>220-44-2480</b>  |  | 17. INFORMANT <b>FAMILY RECORDS</b>   |                                  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Coronary Thrombosis</b><br>DUE TO (b) _____<br>DUE TO (c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |   |  |   | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)  |  |   |  |   |                                  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |   |                                  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. _____ p.m. _____ 19 _____   |  | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>  |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)                            |                                  |
| 20f. (City or town) _____ (County) _____ (State) _____  |  | 21. I certify that (I) (this hospital) attended the deceased from <b>JAN 2<sup>nd</sup>, 1958</b> , to <b>Dec 28, 1967</b> , that (I) (we) last saw the deceased alive on <b>DEC. 27<sup>th</sup>, 1967</b> , and that death occurred at <b>2:37 PM</b> , from the causes and on the date stated above. |  |   |                                  |
| 22a. SIGNATURE <b>John X. Quinn</b>   |  | 22b. DATE SIGNED <b>12/29/67</b>  |  | 22c. PHYSICIAN'S NAME (Type) _____  |                                  |
| 22d. ADDRESS _____  |  | 22e. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>  |  |   |                                  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>   |  | 23b. DATE THEREOF <b>12/30/67</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY <b>NEW CATHEDRAL</b>   |                                  |
| 23d. LOCATION (City, town or county) <b>BALTO. CITY MD.</b>   |  | 23e. LOCATION (State) _____   |  |   |                                  |
| 24. FUNERAL DIRECTOR <b>John Burns and Son</b>  |  | 24a. ADDRESS _____  |  | 24b. REC'D BY REGISTRAR <b>JAN 3 1968</b>   |                                  |
| 24c. REGISTRAR'S SIGNATURE <b>Charles Judge</b>   |  | 24d. DATE _____   |  |   |                                  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

16715

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

16701

|   |  |  |  |
|---|--|--|--|
| 1 PLACE OF DEATH<br>a. COUNTY <u>Baltimore</u><br>MARYLAND  |  | 2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)<br>a. STATE <u>md</u><br>b. COUNTY <u>Baltimore</u>                   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Essex</u>  |  | c. LENGTH OF STAY IN 1b<br><u>3 mo</u>   |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><u>Day Hall Nursing Home</u>  |  | d. STREET ADDRESS<br><u>1416 Wilson Point Rd</u>   |  |
| 3 NAME OF DECEASED<br>(Type or print)<br><u>Margaret E. Walker</u>  |  | 4 DATE OF DEATH<br>Month <u>12</u> Day <u>30</u> Year <u>1967</u>  |  |
| 5 SEX<br><u>Female</u>  | 6. COLOR OR RACE<br><u>white</u>   | 7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><u>9/7/1882</u>                                    |
| 9. AGE (In years lost birthday)<br><u>85</u> yrs  |  | 10. IF UNDER 1 YEAR<br>Months <u>12</u> Days <u>30</u> Hours <u>19</u> Min <u>67</u>   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Domestic Work</u>   |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>Private Home</u>   |  |
| 11 BIRTHPLACE (County & State, or foreign country)<br><u>md.</u>  |  | 12 CITIZEN OF WHAT COUNTRY?<br><u>U.S.A.</u>   |  |
| 13 FATHER'S NAME<br><u>James Turner</u>   |  | 14 MOTHER'S MAIDEN NAME<br><u>Lucie Varina</u>   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) (If yes give war or dates of service)<br><u>No</u>   |  | 16 SOCIAL SECURITY NO<br><u>220-30-3648</u>  |  |
| 17 INFORMANT<br><u>Joseph Floyd</u>   |  | Address<br><u>1416 Wilson Point Rd.</u>  |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I DEATH WAS CAUSED BY<br><u>4221</u> IMMEDIATE CAUSE (a)<br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b)<br>DUE TO<br>(c)              |  | INTERVAL BETWEEN ONSET AND DEATH<br><u>45 CVD</u>  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |  |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1B)   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. <u>19</u> p.m.  | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Not While <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   | 20f. (City or town) (County) (State)                                   |
| 21. I certify that (I) (this hospital) attended the deceased from <u>12/29</u> , 19 <u>67</u> , to <u>12/29</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>12/29</u> , 19 <u>67</u> , and that death occurred at <u>3 P</u> M, from causes on the date stated above |  |  |  |
| 22a. SIGNATURE<br><u>Hudson Fesche</u>  |  | 22b. DATE SIGNED<br><u>12/29/67</u>  |  |
| 22c. PHYSICIAN'S NAME (Type)<br><u>Hudson Fesche</u>  |  | 22d. ADDRESS<br><u>University Hosp.</u>  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Buried</u>  | 23b. DATE THEREOF<br><u>1/2/68</u>   | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Landon Park Cem.</u>  | 23d. LOCATION (City or Town) (County) (State)<br><u>Baltimore, md.</u> |
| 24 FUNERAL DIRECTOR<br><u>John J. Lawrence</u>  |  | 25a. DATE<br><u>90 Collins St.</u>   |  |
| 25b. DATE<br><u>23 Jan</u>  |  | 25c. DATE<br><u>23 Jan</u>   |  |





# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## CERTIFICATE OF DEATH

16716

16716

|  |   |   |   |   |  |
|--|---|---|---|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>BALTIMORE</b><br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FORT HOWARD</b>   |   | c. LENGTH OF STAY IN 1b <b>42 DAYS</b>  |   | 2. USUAL RESIDENCE (Where deceased lived, if institut on Residence before adm ssion)<br>a. STATE <b>MARYLAND</b><br>b. COUNTY <b>BALTIMORE</b><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BALTIMORE</b> |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>VETERANS ADMINISTRATION HOSPITAL</b>   |   |   | d. STREET ADDRESS <b>418 PITTSBURG AVENUE</b>                             |   | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print)<br>First <b>DAVID</b> Middle <b>LEE</b> Last <b>WALLS</b>  |   |   | 4. DATE OF DEATH<br>Month <b>DECEMBER</b> Day <b>23</b> Year <b>19 67</b> |   |  |
| 5. SEX <b>MALE</b>   | 6. COLOR OR RACE <b>NEGROID</b>   | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <b>7 3 17</b>  | 9. AGE (In years last birthday) <b>50</b> yrs.  | IF UNDER 1 YEAR<br>Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min <b>0</b>                   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>NURSING ASS'T</b>   |   | 10b. KIND OF BUSINESS OR INDUSTRY <b>HOSPITAL</b>   |   | 11. BIRTHPLACE (County & State, or foreign country) <b>YORK CO., S.C.</b>   |  |
| 13. FATHER'S NAME <b>ELIHUE WALLS</b>  |   |   | 12. CITIZEN OF WHAT COUNTRY? <b>USA</b>                                   |   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>YES</b>   |   | 16. SOCIAL SECURITY NO <b>WW II 249 22 09 90</b>  |   | 17. INFORMANT Address <b>CLINICAL RECORDS VA HOSP FT HOWARD, MD</b>   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>C.V.A. (THROMBOSIS OF RT MIDDLE CEREBRAL ARTERY)</b><br><b>33dA</b> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____    |   |   |   |   | INTERVAL BETWEEN ONSET AND DEATH <b>-</b>  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |   |   |   |   | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Port II of item 18)   |   |   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour <b>19</b> a.m. p.m.   | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/><br>of work of work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  | 20f. (City or town) (County) (State)                                      |   |  |
| 21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>11 11 67</b> , 19__, to <b>12 23 67</b> , 19__, that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>12 23 67</b> , 19__, and that death occurred at <b>1:30 AM</b> , from causes and on the date stated above |   |   |   |   |  |
| 22a. SIGNATURE <b>B.R. KRISHNA MURTHY M.D.</b>   |   | ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>                                | 22b. DATE SIGNED <b>12 23 67</b>  |   |  |
| 22c. PHYSICIAN'S NAME (Type) <b>B.R. KRISHNA MURTHY</b>  |   | 22d. ADDRESS <b>VA HOSPITAL FORT HOWARD, MARYLAND</b>   |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)  | 23b. DATE THEREOF <b>12-28-67</b>   | 23c. NAME OF CEMETERY OR CREMATORY <b>ROCK GROVE CHURCH</b>   |   | 23d. LOCATION (City or Town) (County) (State) <b>ROCK HILL, S.C.</b>  |  |
| 24. FUNERAL DIRECTOR <b>MORTON DYETT FUNERAL HOME, 1701 LAURENS</b>  |   | ADDRESS <b>BALTO, MD</b>  | 25a. REC'D BY REGISTRAR <b>DEC 28 1967</b>                                | 25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>   |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

8:1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers - Pages 1 and 2 - should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

| 16711  |  | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 |  | CERTIFICATE OF DEATH  |  | 16711 |  |
|--|--|---|--|---|--|-------|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Baltimore</b><br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Mount Wilson</b><br>c. LENGTH OF STAY IN 1b<br><b>Mount Wilson State Hospital</b><br>d. NAME OF HOSPITAL, OR INSTITUTION (If not in hospital, give street address)<br><b>Mount Wilson State Hospital</b> |  |   |  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <b>Md.</b><br>b. COUNTY<br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>BALTIMORE</b><br>d. STREET ADDRESS<br><b>1228 Caroline St</b>   |  |       |  |
| 3. NAME OF DECEASED<br>(Type or print)<br>First <b>DANIEL</b> Middle <b>WASHINGTON</b> Last<br>4. DATE OF DEATH<br>Month <b>DEC.</b> Day <b>4</b> Year <b>1967</b>   |  |   |  | 5. SEX <b>M.</b> 6. COLOR OR RACE <b>N</b> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH<br><b>5-16-1894</b> 9. AGE (In years, last birthday)<br><b>73</b> 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>LABORER</b> 11. BIRTHPLACE (County & State, or foreign country)<br><b>SOUTH CAROLINA - JAMESTOWN USA</b> |  |       |  |
| 12. CITIZENSHIP OF WHAT COUNTRY?<br><b>USA</b>   |  |   |  | 13. FATHER'S NAME<br><b>ELIAS WASHINGTON</b>  |  |       |  |
| 14. MOTHER'S MAIDEN NAME<br><b>HATTIE MILLER</b>   |  |   |  | 15. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) (If yes give war or dates of service)<br><b>NO</b>   |  |       |  |
| 16. SOCIAL SECURITY NO   |  |   |  | 17. INFORMANT<br>Address<br><b>Records, Mt. Wilson State Hospital</b>   |  |       |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <b>MYOCARDIAL INFARCT</b><br>DUE TO (b) <b>ARTERIO SCLEROTIC HEART DISEASE</b><br>DUE TO (c)<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.                       |  |   |  | INTERVAL BETWEEN ONSET AND DEATH  |  |       |  |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |  |   |  | 19. WAS AUTOPSY PERFORMED?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  |       |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)   |  |   |  | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)  |  |       |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. 19   |  |   |  | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work  |  |       |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |  |   |  | 20f. (City or town) (County) (State)  |  |       |  |
| 21. I certify that (I) (this hospital) attended the deceased from <b>4-19-1967</b> to <b>12-4-1967</b> , that (I) (we) last saw the deceased alive on <b>12-4-67</b> 19__, and that death occurred on <b>12-4-67</b> 19__, from causes and on the date stated above.   |  |   |  | 22a. SIGNATURE<br><b>W. Newcomer</b> M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>  |  |       |  |
| 22b. DATE SIGNED   |  |   |  | 22c. PHYSICIAN'S NAME (Type)<br><b>Wm. Newcomer, M.D., Superintendent</b>   |  |       |  |
| 22d. ADDRESS<br><b>Mount Wilson, Maryland</b>  |  |   |  | 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>REMOVAL</b>   |  |       |  |
| 23b. DATE THEREOF<br><b>12-8-67</b>  |  |   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>MONKS CORNER, S.C.</b>   |  |       |  |
| 23d. LOCATION (City or Town) (County) (State)  |  |   |  | 24. FUNERAL DIRECTOR<br><b>Elliot Fun. Home</b>   |  |       |  |
| 25a. REC'D BY REGISTRAR<br><b>DEC 8 1967</b>   |  |   |  | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judson</b>   |  |       |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

|  |  |  |  |
|--|--|--|--|
| 1 PLACE OF DEATH<br>a. COUNTY <b>BALTIMORE</b><br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FORT HOWARD</b><br>c. LENGTH OF STAY IN 1b <b>10 DAYS</b><br>d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>VA HOSPITAL, FORT HOWARD, MARYLAND</b>  |  | 2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)<br>a. STATE <b>MARYLAND</b><br>b. COUNTY <b>BALTIMORE</b><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BALTIMORE</b><br>d. STREET ADDRESS <b>1603 MILLER STREET</b><br>e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 3 NAME OF DECEASED (Type or print)<br>First <b>JESSIE</b> Middle <b>WASHINGTON</b> Last <b>WASHINGTON</b>  |  | 4 DATE OF DEATH<br>Month <b>DECEMBER</b> Day <b>10</b> Year <b>1967</b>  |  |
| 5 SEX <b>MALE</b>  | 6. COLOR OR RACE <b>NEGRO</b>  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>  | 8. DATE OF BIRTH <b>1/15/96</b>  |
| 9. AGE (In years lost birthday) <b>71</b> yrs  |  | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>COOK</b>   |  |
| 10b. KIND OF BUSINESS OR INDUSTRY <b>-</b>   |  | 11. BIRTHPLACE (County & State, or foreign country) <b>BALTIMORE, MARYLAND</b>   |  |
| 12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>   |  | 13. JAMES'S NAME <b>JAMES WASHINGTON</b>   |  |
| 14. MOTHER'S MAIDEN NAME <b>SARAH KUCKIES</b>  |  | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>YES WW I</b>  |  |
| 16. SOCIAL SECURITY NO <b>218 05 01 96</b>   |  | 17. INFORMANT <b>CLINICAL RECORDS, VA HOSP, FORT HOWARD, MARYLAND</b>  |  |
| 18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>BRONCHOPNEUMONIA</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>METASTATIC CARCINOMA REGIONAL LYMPH NODES, LUNGS AND LIVER</b><br>(c) <b>SURGICAL ABSENCE, LARYNX</b> |  | INTERVAL BETWEEN ONSET AND DEATH <b>RECENT</b>   |  |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |  | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)   |  | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour 'a.m. 19<br>p.m.  | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Not While <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)  | 20f. (City or town) (County) (State)                                     |
| 21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>12/1/67</b> , 19__, to <b>12/10/67</b> , 19__, that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on <b>12/10/67</b> , 19__, and that death occurred at <b>7:45PM</b> , from causes and on the date stated above.                          |  |  |  |
| 22a. SIGNATURE<br><i>George C. McElfrick</i><br>22c. PHYSICIAN'S NAME (Type) <b>GEORGE C. MC ELFRICK, M. D.</b>  |  | 22b. DATE SIGNED <b>12/11/67</b>   |  |
| 22d. ADDRESS <b>VA HOSPITAL, FORT HOWARD, MARYLAND</b>   |  | 22e. MED. DIRECTOR <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>   |  |
| 23a. BURIAL, CREMATON, REMOVAL (Specify) <b>BURIAL</b>   | 23b. DATE THEREOF <b>12-15-67</b>  | 23c. NAME OF CEMETERY OR CREMATORY <b>BALTIMORE NATIONAL</b>   | 23d. LOCATION (City or Town) (County) (State) <b>BALTIMORE, MARYLAND</b> |
| 24. FUNERAL DIRECTOR   |  | 25a. REC'D BY REGISTRAR <b>DATE DEC 12 1967</b>  | 25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>                          |



DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

16714

|   |   |   |  |
|---|---|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY<br><b>Baltimore</b>  |   | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)<br>e. STATE<br><b>Maryland</b>  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Reisterstown</b>   |   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Baltimore</b>  |  |
| c. LENGTH OF STAY IN b.<br><b>5 months</b>  |   | d. STREET ADDRESS<br><b>4203 Springdale Ave.</b>  |  |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)<br><b>Bent Nursing Home</b>  |   | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |
| 3. NAME OF DECEASED<br>(Type or print)<br>First Middle Last<br><b>Grace Edna Waters</b>   |   | 4. DATE OF DEATH<br>Month Day Year<br><b>December 14 19 67</b>  |  |
| 5. SEX<br><b>Female</b>   | 6. COLOR OR RACE<br><b>White</b>  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>Nov. 30, 1897</b>                                   |
| 9. AGE (In years last birthday)<br><b>70</b> yrs.   |   | 10. IF UNDER 1 YEAR<br>Months Days<br><b>1877</b>   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housewife</b>   |   | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>-----</b>   |  |
| 11. BIRTHPLACE (County & State, or foreign country)<br><b>Washington Co., Md.</b>   |   | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  |
| 13. FATHER'S NAME<br><b>John Z. Draper</b>  |   | 14. MOTHER'S MAIDEN NAME<br><b>Unknown</b>  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service)<br><b>No</b>  |   | 16. SOCIAL SECURITY NO. 17. INFORMANT<br><b>213-50-2951 Mrs. Aaron Seidler</b>  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Abdominal Aneurysm - ruptured</b><br><b>451X</b> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <b>Arteriosclerosis - generalized</b><br>DUE TO (c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a): |   | INTERVAL BETWEEN ONSET AND DEATH<br><b>1 week</b><br><b>Year</b>  |  |
| 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   |   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a.m.<br>p.m.<br><b>19</b>   | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  | 20f. (City or town) (County) (State)                                       |
| 21. I certify that (I) (this hospital) attended the deceased from <b>July 23, 1967</b> to <b>December 14, 1967</b> , that (I) (we) last saw the deceased alive on <b>December 14, 1967</b> , and that death occurred at <b>10 P</b> M, from the causes and on the date stated above.  |   |   |  |
| 22a. SIGNATURE<br><b>Clarence E. McWilliams</b> M.D.  |   | 22b. DATE SIGNED<br><b>December 14, 1967</b>  |  |
| 22c. PHYSICIAN'S NAME (Type)<br><b>Clarence E. McWilliams</b>   |   | 22d. ADDRESS<br><b>11904 Reisterstown Rd. Reisterstown, Md.</b>   |  |
| 23a. BURIAL, CREMATION REMOVAL (Specify)<br><b>Burial</b>   | 23b. DATE THEREOF<br><b>12/18/67</b>  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>St. Paul Cemetery</b>  | 23d. LOCATION (City, town or county) (State)<br><b>Washington Co., Md.</b> |
| 24. FUNERAL DIRECTOR'S SIGNATURE<br><b>H. J. Seckhardt</b>  |   | 25a. REC'D BY REGISTRAR<br><b>DEC 19 1967</b>   |  |
| ADDRESS<br><b>Owings Mills, Md.</b>   |   | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

16720

16715

|  |  |   |   |
|--|--|---|---|
| 1 PLACE OF DEATH<br>a. COUNTY <b>BALTIMORE</b><br>MARYLAND   |  | 2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission)<br>a. STATE <b>MARYLAND</b><br>b. COUNTY <b>BALTIMORE</b>              |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>BALTIMORE</b>   |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>LUTHERVILLE MARYLAND</b>   |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>GREATER BALTIMORE MED. CENTRE</b>   |  | d. STREET ADDRESS<br><b>805 JAMISON Rd.</b>   |   |
| 3 NAME OF DECEASED<br>(Type or print)<br>First <b>ADOLPH</b> Middle <b>WEBER</b> Last <b>WEBER</b>   |  | 4 DATE OF DEATH<br>Month <b>Dec.</b> Day <b>1</b> Year <b>1967</b>  |   |
| 5 SEX<br><b>MALE</b>   | 6 COLOR OR RACE<br><b>CUU</b>  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>9-18-1897</b>  |
| 9a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>(RETIRED)</b>  |  | 9b. KIND OF BUSINESS OR INDUSTRY  | 9 AGE (In years last birthday)<br><b>70</b>   |
| 10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>(RETIRED)</b>   |  | 10b. KIND OF BUSINESS OR INDUSTRY   | 11 BIRTHPLACE (County & State or foreign country)<br><b>CINCINNATI, OHIO</b>                      |
| 13. FATHER'S NAME<br><b>ADOLPH WEBER</b>   |  | 12 C. TIZEN OF WHAT COUNTRY<br><b>US</b>  |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)  |  | 16 SOCIAL SECURITY NO.<br><b>246-07-4699</b>  | 17 INFORMANT<br><b>PT. CHART.</b>   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br><b>102X IMMEDIATE CAUSE (a) Multiple myeloma</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) DUE TO<br>(c) DUE TO  |  |   | INTERVAL BETWEEN ONSET AND DEATH  |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)  |  |   | 19. WAS AUTOPSY PERFORMED?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)   |   |
| 20c TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m. <b>19</b>  | 20d INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  | 20f (City or town) (County) (State)   |
| 21 I certify that (I) (this hospital) attended the deceased from <b>Nov 24<sup>th</sup></b> , 19 <b>67</b> , to <b>Dec 1<sup>st</sup></b> , 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>Dec 1<sup>st</sup></b> , 19 <b>67</b> , and that death occurred at <b>2:33 PM</b> , from causes and on the date stated above. |  |   |   |
| 22a SIGNATURE<br><b>Duncan McGhie</b>  |  | 22b DATE SIGNED<br><b>Dec 1<sup>st</sup> 1967</b>   |   |
| 22c PHYSICIAN'S NAME (Type)<br><b>DUNCAN MCGHIE</b>  |  | 22d ADDRESS<br><b>616 E 34<sup>th</sup> St. Balto Md.</b>   |   |
| 23a BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  | 23b DATE THEREOF<br><b>12-4-67</b>   | 23c NAME OF CEMETERY OR CREMATORY<br><b>St. Francis Xavier</b>  | 23d LOCATION (City or Town) (County) (State)<br><b>Willard, Ohio</b>                              |
| 24. FUNERAL DIRECTOR<br><b>Wm. Cook-Brooks</b>   |  | 25a. REC'D BY REGISTRAR<br><b>DEC 5 1967</b>  |   |
| 25b. REGISTRAR'S SIGNATURE<br><b>John J. Judge</b>   |  | 25c. REGISTRAR'S SIGNATURE  |   |

Powson, Towson, Md. 21204



1  
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 42 hours after death.

16721  
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH  
15716

|   |                                  |   |   |  |  |  |   |
|---|----------------------------------|---|---|--|--|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Baltimore</b> MARYLAND  |                                  |   |   | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Harford</b> |  |  |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Towson</b>   |                                  |   |   | c. LENGTH OF STAY IN 1b<br><b>140 days</b>   |  |  |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>Greater Baltimore Medical Center</b>   |                                  |   |   | d. STREET ADDRESS<br><b>R. D. 6</b>  |  |  |   |
| 3. NAME OF DECEASED (Type or print)<br>First <b>LOUELLA</b> Middle <b>NMN</b> Last <b>WELLS</b>   |                                  |   |   | 4. DATE OF DEATH<br>Month <b>December</b> Day <b>16</b> Year <b>1967</b>   |  |  |   |
| 5. SEX<br><b>F</b>  | 6. COLOR OR RACE<br><b>White</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>APRIL 20, 1922</b> |  | 9. AGE (In years last birthday) <b>45</b> yrs. |  | IF UNDER 1 YEAR<br>Months Days Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>housewife</b>   |                                  | 10b. KIND OF BUSINESS OR INDUSTRY   |   | 11. BIRTHPLACE (County & State, or foreign country)<br><b>Rich. Co., Va.</b>   |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                          |   |
| 13. FATHER'S NAME<br><b>Sidney Meddow</b>   |                                  |   |   | 14. MOTHER'S MAIDEN NAME<br><b>Louzella Pri Wiley</b>  |  |  |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)<br><b>No</b>  |                                  | 16. SOCIAL SECURITY NO.<br><b>No</b>  |   | 17. INFORMANT<br><b>Ms. George J. Wells</b>  |  | Address  |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Carcinoma of breast</b><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>170X</b><br>DUE TO<br>(c) |                                  |   |   |  |  |  | INTERVAL BETWEEN ONSET AND DEATH          |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)  |                                  |   |   |  |  |  |   |
| 19. WAS AUTOPSY PERFORMED?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |                                  |   |   |  |  |  |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |   |  |  |  |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m. <b>19</b>  |                                  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>   |   | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |  | 20f. (City or town) (County) (State)                                   |   |
| 21. I certify that (I) (this hospital) attended the deceased from <b>July 31</b> , 19 <b>67</b> , to <b>Dec. 16</b> , 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>Dec. 16</b> , 19 <b>67</b> , and that death occurred at <b>9:20 PM</b> , from the causes and on the date stated above. |                                  |   |   |  |  |  |   |
| 22a. SIGNATURE<br><b>John E. Adams</b>  |                                  |   |   | 22b. DATE SIGNED<br><b>Dec. 17, 1967</b>   |  | 22c. PHYSICIAN'S NAME (Type)<br><b>John E. Adams, M.D.</b>             |   |
| 22d. ADDRESS<br><b>6701 N. Charles St., Towson, Md.</b>   |                                  |   |   |  |  |  |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)   |                                  | 23b. DATE THEREOF<br><b>10/19/1967</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>St. James Cemetery</b>  |  | 23d. LOCATION (City, town or county) (State)<br><b>Towson Co., Md.</b> |   |
| 24. FUNERAL DIRECTOR<br><b>C. M. Woltz Box 241 Sykesville, Md.</b>  |                                  |   |   | 25a. REC'D BY REGISTRAR<br><b>DEC 21 1967</b>  |  |  |   |
|   |                                  |   |   | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>   |  |  |   |



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

16722

15717

|  |                                  |   |                                   |  |   |  |  |
|--|----------------------------------|---|-----------------------------------|--|---|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Baltimore</b> MARYLAND   |                                  |   |                                   | 2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>                         |   |  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Owings Mills</b>  |                                  | c. LENGTH OF STAY IN 1b<br><b>58 days</b>   |                                   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Baltimore</b>   |   |  |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>Rosewood State Hospital</b>   |                                  |   |                                   | d. STREET ADDRESS<br><b>2110 Anna Avenue</b>   |   |  |  |
| 3. NAME OF DECEASED<br>(Type or print) <b>Paul Robin WEST</b>  |                                  |   |                                   | 4. DATE OF DEATH<br>Month <b>12</b> Day <b>8</b> Year <b>1967</b>  |   |  |  |
| 5. SEX<br><b>Male</b>  | 6. COLOR OR RACE<br><b>White</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>4-3-54</b> | 9. AGE (In years last birthday)<br><b>13</b> yrs   | F UNDER 1 YEAR IF UNDER 24 HRS<br>Months Days Hours Min |  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Dependent</b>  |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>none</b>  |                                   | 11. BIRTHPLACE (State or foreign country)<br><b>Baltimore City, Md.</b>  |   | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                            |  |
| 13. FATHER'S NAME<br><b>Howard Monroe West</b>   |                                  |   |                                   | 14. MOTHER'S MAIDEN NAME<br><b>Elizabeth Ellen Carnes</b>  |   |  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><b>no</b>   |                                  | 16. SOCIAL SECURITY NO<br><b>none</b>   |                                   | 17. INFORMANT Address<br><b>Rosewood State Hospital, Owings Mills, Md.</b>   |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <b>Asphyxia (Bread in larynx)</b><br>DUE TO (b) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) _____<br>INTERVAL BETWEEN ONSET AND DEATH <b>23 min.</b>  |                                  |   |                                   |  |   |  |  |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br><b>Severe mental retardation</b>   |                                  |   |                                   |  |   |  |  |
| 20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH? <input checked="" type="checkbox"/>  |                                  | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)<br><b>Choked on bread</b>  |                                   |  |   |  |  |
| 20c. TIME OF INJURY Month, Day, Year<br><b>11:55 am 12/8 1967</b>  |                                  | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>   |                                   | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)<br><b>Holland Cottage</b>  |   | 20f. (City or town) (County) (State)<br><b>Owings Mills, Balto., Md.</b> |  |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from. Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> |                                  |   |                                   |  |   |  |  |
| ACTUAL SIGNATURE <b>D. D. Caples</b> M.D.<br>EXAMINER'S NAME (Type) <b>D. D. Caples, M.D.</b>  |                                  |   |                                   | 22. DATE SIGNED<br><b>12/8/67</b><br>DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/><br>Address (Street, city, town, or county) <b>Reisterstown, Md.</b> |   |  |  |
| 23a. BURIAL CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |                                  | 23b. DATE THEREOF<br><b>12/11/67</b>  |                                   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Loudon Park Cemetery</b>  |   | 23d. LOCATION (City or Town) (County) (State)<br><b>Baltimore, Md.</b>   |  |
| 24. FUNERAL DIRECTOR ADDRESS<br><b>Ullrich Funeral Home Dundalk, Md.</b>   |                                  |   |                                   | 25a. REC'D BY REGISTRAR<br>DATE <b>DEC 13 1967</b>   |   | 25b. REGISTRAR'S SIGNATURE<br><b>J. Charles Jones</b>                    |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

16723

16718

|  |   |  |   |
|--|---|--|---|
| 1 PLACE OF DEATH<br>a. COUNTY<br><b>BALTIMORE</b><br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>TOWSON</b><br>c. LENGTH OF STAY IN 1b<br><b>1</b><br>d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>ST. JOSEPH HOSPITAL</b>  |   | 2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)<br>a. STATE<br><b>MARYLAND</b><br>b. COUNTY<br><b>-</b><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>BALTIMORE</b><br>d. STREET ADDRESS<br><b>1013 BEAUMONT AVE. #21212</b><br>e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |
| 3 NAME OF DECEASED<br>(Type or print)<br><b>ALFRED</b><br>First Middle Last<br><b>WHITE</b>  |   | 4. DATE OF DEATH<br>Month Day Year<br><b>DECEMBER 18 1967</b>  |   |
| 5 SEX<br><b>MALE</b>   | 6. COLOR OR RACE<br><b>NEGRO</b>  | 7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>   | 8. DATE OF BIRTH<br><b>DECEMBER 24, 1922</b><br>9. AGE (In years last birthday) <b>44</b> yrs<br>IF UNDER 1 YEAR Months Days Hours Min<br><b>44</b> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>SELF-EMPLOYED</b>  |   | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>ALF'S HAULING CO.</b>  |   |
| 11. BIRTHPLACE (County & State, or foreign country)<br><b>Accomac Co., VIRGINIA</b>  |   | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |   |
| 13. FATHER'S NAME<br><b>GEORGE WHITE</b>   |   | 14. MOTHER'S MAIDEN NAME<br><b>STELLA WHITE</b>  |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><b>No.</b>  |   | 16. SOCIAL SECURITY NO<br><b>1013 Beaumont Ave</b>   |   |
| 17. INFORMANT<br><b>Mrs. Doris White</b>   |   | Address<br><b>1013 Beaumont Ave</b>  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Encephalomalacia of brain stem</b><br>DUE TO<br>(b) <b>thrombosis of basilar artery</b><br>DUE TO<br>(c) <b>congenital aneurysm of basilar artery</b><br>7547<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last |   | INTERVAL BETWEEN ONSET AND DEATH   |   |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)  |   | 19. WAS AUTOPSY PERFORMED?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |   | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)  |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m. <b>19</b>   | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)  | 20f. (City or town) (County) (State)  |
| 21. I certify that <b>Dr. (this hospital)</b> attended the deceased from <b>DECEMBER 18, 1967</b> , to <b>DECEMBER 18, 1967</b> that <b>(X)</b> (we) last saw the deceased alive on <b>DECEMBER 18, 1967</b> , and that death occurred at <b>11:05 PM</b> from causes and on the date stated above.  |   |  |   |
| 22a. SIGNATURE<br><b>Lawrence F. Misanik, M.D.</b>   |   | 22b. DATE SIGNED<br><b>12/19/67</b>  |   |
| 22c. PHYSICIAN'S NAME (Type)<br><b>Lawrence F. Misanik, M.D.</b>   |   | 22d. ADDRESS<br><b>7620 York Rd., Towson, Md., 21204</b>   |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>   | 23b. DATE THEREOF<br><b>12-22-67</b>  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Pleasant Rest Cem.</b>  | 23d. LOCATION (City or Town) (County) (State)<br><b>Towson, Maryland</b>  |
| 24. FUNERAL DIRECTOR<br><b>MORTON &amp; DYETT F.H.</b>   |   | 25a. REC'D BY REGISTRAR<br><b>DEC 21 1967</b><br>25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>  |   |





CERTIFICATE OF DEATH

16724

13719

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 2 and 3, and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

|   |  |  |                         |   |   |  |   |
|---|--|--|-------------------------|---|---|--|---|
| 1 PLACE OF DEATH<br>a. COUNTY <u>Baltimore</u> MARYLAND   |  |  |                         | 2 USUAL RESIDENCE (Where deceased lived, if institution; Res. before admission)<br>a. STATE <u>Md.</u> b. COUNTY <u>_____</u>                   |   |  |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Catonsville</u>  |  |  | c. LENGTH OF STAY IN 1b |   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Baltimore</u> 20-✓ |  |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><u>Shangri La Nursing Home</u>  |  |  |                         | d. STREET ADDRESS<br><u>11 S. Rosedale St.</u>  |   | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |
| 3 NAME OF DECEASED (Type or print)<br>First Middle Last<br><u>Leo H. White</u>  |  |  |                         | 4 DATE OF DEATH<br>Month Day Year<br><u>Dec. 10, 1967</u>   |   |  |   |
| 5 SEX<br><u>M</u>   |  | 6 COLOR OR RACE<br><u>Cauc.</u>  |                         | 7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 8 DATE OF BIRTH<br><u>2/10/18</u>  |   |
| 9 AGE (In years last birthday)<br><u>49</u> yrs   |  | IF UNDER 1 YEAR<br>Months Days Hours Min   |                         | 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Violin Brothers</u>                           |   | 11 BIRTHPLACE (County & State, or foreign country)<br><u>Balto., Md.</u>               |   |
| 12 CITIZEN OF WHAT COUNTRY?<br><u>USA</u>   |  | 13 FATHER'S NAME<br><u>Harry T. White</u>  |                         | 14 MOTHER'S MAIDEN NAME<br><u>Barbara Zizzi</u>   |   |  |   |
| 15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)  |  | 16 SOCIAL SECURITY NO.<br><u>218-05-3858</u>   |                         | 17 INFORMANT<br><u>Mary J. Young</u><br><u>11 S. Rosedale St.</u> Address   |   |  |   |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <u>Paralysis agitans</u><br>DUE TO (b) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ |  |  |                         |   |   |  | INTERVAL BETWEEN ONSET AND DEATH<br><u>40 yrs</u>                                     |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |  |  |                         |   |   |  | 19 WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)                |                         |   |   |  |   |
| 20c TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m. <u>19</u>   |  | 20d INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> |                         | 20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |   | 20f (City or town) (County) (State)  |   |
| 21. I certify that (I) (this hospital) attended the deceased from <u>Oct</u> , 19 <u>40</u> , to <u>Dec 9</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>Dec 9, 1967</u> , and that death occurred at _____ M, from causes and on the date stated above.        |  |  |                         |   |   |  |   |
| 22a. SIGNATURE<br><u>Kennard Yaffe</u>  |  |  |                         | M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>              |   | 22b. DATE SIGNED<br><u>12/11/67</u>  |   |
| 22c. PHYSICIAN'S NAME (Type)<br><u>Kennard Yaffe</u>  |  |  |                         | 22d. ADDRESS<br><u>5501 Forest Park Ave.</u>  |   |  |   |
| 23a BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial</u>   |  | 23b DATE THEREOF<br><u>12/12/67</u>  |                         | 23c NAME OF CEMETERY OR CREMATORY<br><u>Loudon Park Cem.</u>  |   | 23d LOCATION (City or Town) (County) (State)<br><u>Baltimore, Md.</u>                  |   |
| 24 FUNERAL DIRECTOR<br><u>Witzke F. D. - 4101 Edmondson Av.</u>   |  |  |                         | 25a REC'D BY REGISTRAR<br>DATE <u>DEC 11 1967</u>   |   | 25b REGISTRAR'S SIGNATURE<br><u>[Signature]</u>  |   |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15-14  
25M 1/67

| MARYLAND STATE DEPARTMENT OF HEALTH  |                                  |   |                                   |
|--|----------------------------------|---|-----------------------------------|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |                                  |   |                                   |
| CERTIFICATE OF DEATH   |                                  |   |                                   |
| 16720  |                                  |   |                                   |
| 1. PLACE OF DEATH<br>a. COUNTY <b>Baltimore</b><br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Fort Howard</b>  |                                  | 2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission)<br>a. STATE <b>Maryland</b><br>b. COUNTY <b>Baltimore</b> |                                   |
| c. LENGTH OF STAY in 1b<br><b>4 days</b>   |                                  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Baltimore</b>  |                                   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>Veterans Administration Hospital</b>  |                                  | d. STREET ADDRESS<br><b>60 W. Lombard Street</b>  |                                   |
| e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                                  |   |                                   |
| 3. NAME OF DECEASED<br>(Type or print) <b>HENRY</b><br>First Middle Last<br><b>HUSTON WILBUR</b>   |                                  | 4. DATE OF DEATH<br>Month Day Year<br><b>Dec. 26 19 67</b>  |                                   |
| 5. SEX<br><b>Male</b>  | 6. COLOR OR RACE<br><b>White</b> | 7. MARRIED<br><input type="checkbox"/> NEVER MARRIED<br><input checked="" type="checkbox"/> WIDOWED<br><input type="checkbox"/> DIVORCED        | 8. DATE OF BIRTH<br><b>3/7/57</b> |
| 9. AGE (In years last birthday)<br><b>10 yrs</b>   |                                  | 10. IF UNDER 1 YEAR<br>Months Days Hours Min  |                                   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Machine Operator</b>   |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Slipcover Factory</b>   |                                   |
| 11. BIRTHPLACE (County & State, or foreign country)<br><b>Indiana</b>  |                                  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |                                   |
| 13. FATHER'S NAME  |                                  | 14. MOTHER'S MAIDEN NAME  |                                   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) <b>Yes</b><br>(If yes give war or dates of service) <b>WW-1</b>   |                                  | 16. SOCIAL SECURITY NO.<br><b>216 16 69 05</b>  |                                   |
| 17. INFORMANT<br><b>Clinical Recds, VA Hospital, Fort Howard Md.</b>   |                                  | Address   |                                   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY:<br><b>4301</b><br>IMMEDIATE CAUSE (a) <b>ACUTE MYOCARDIAL INFARCTION</b><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) <b>ARTERIOSCLEROTIC HEART DISEASE</b><br>DUE TO<br>(c) <b>Unknown</b> |                                  | INTERVAL BETWEEN ONSET AND DEATH<br><b>Unknown</b>  |                                   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br><b>REMOTE LEFT MIDDLE CEREBRAL ARTERY THROMBOSIS</b>  |                                  | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |                                   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                                  | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)  |                                   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m. <b>19</b>   |                                  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>                                       |                                   |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |                                  | 20f. (City or town) (County) (State)  |                                   |
| 21. I certify that (I)-(this hospital) attended the deceased from <b>Dec. 22</b> , 19 <b>67</b> , to <b>Dec. 26</b> , 19 <b>67</b> ; that (I)-(we) last saw the deceased alive on <b>Dec. 26</b> , 19 <b>67</b> , and that death occurred at <b>5:55 P.M.</b> , from causes and on the date stated above.  |                                  |   |                                   |
| 22a. SIGNATURE<br><b>Neilson Neilson, M.D.</b>   |                                  | 22b. DATE SIGNED<br><b>12/26/67</b>   |                                   |
| 22c. PHYSICIAN'S NAME (Type)<br><b>NEILSON NEILSON, M.D.</b>   |                                  | 22d. ADDRESS<br><b>VA Hospital, Fort Howard, Md.</b>  |                                   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |                                  | 23b. DATE THEREOF<br><b>1/2/68</b>  |                                   |
| 23c. NAME OF CEMETERY OR CREMATORY<br><b>Baltimore National</b>  |                                  | 23d. LOCATION (City or Town) (County) (State)<br><b>Baltimore, Maryland</b>   |                                   |
| 24. FUNERAL DIRECTOR<br><b>ZAMMINO FUNERAL HOME</b>  |                                  | 25a. REC'D BY REGISTRAR<br><b>DATE JAN 2 1968</b>   |                                   |
| 25b. REGISTRAR'S SIGNATURE   |                                  |   |                                   |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

| MARYLAND STATE DEPARTMENT OF HEALTH  |  |                                      |  |   |  |  |  |   |  |  |  |
|--|--|--------------------------------------|--|---|--|--|--|---|--|--|--|
| DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND   |  |                                      |  |   |  |  |  |   |  |  |  |
| 16725  |  |                                      |  |   |  |  |  |   |  |  |  |
| Item #2b & d 1110 1039 14/20/67  |  |                                      |  |   |  |  |  |   |  |  |  |
| 15721  |  |                                      |  |   |  |  |  |   |  |  |  |
| 1. PLACE OF DEATH<br>a. COUNTY <b>Baltimore</b> <b>MARYLAND</b>  |  |                                      |  |   |  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <b>MD.</b> b. COUNTY <b>Balto.</b> |  |   |  |  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Rural - Towson</b>  |  |                                      |  |   |  | c. LENGTH OF STAY IN ID <b>37 days</b>   |  |   |  |  |  |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)<br><b>Greater Baltimore Medical Center</b>  |  |                                      |  |   |  | d. STREET ADDRESS <b>612 New Pittsburg Ave.</b>  |  |   |  |  |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Frank</b> Middle <b>Everetts</b> Last <b>Williams</b>  |  |                                      |  |   |  | 4. DATE OF DEATH<br>Month <b>12</b> Day <b>15</b> Year <b>1967</b>   |  |   |  |  |  |
| 5. SEX<br><b>Male</b>  |  | 6. COLOR OR RACE<br><b>Negro</b>     |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><b>9-16-1907</b>   |  | 9. AGE (In years last birthday)<br><b>60 yrs.</b> |  | IF UNDER 1 YEAR IF UNDER 24 HRS.<br>Months Days Hours Min. |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>LABORER</b>  |  |                                      |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>BETH-STEEL</b>  |  | 11. BIRTHPLACE (County & State, or foreign country)<br><b>BALTIMORE, MARYLAND</b>  |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>     |  |  |  |
| 13. FATHER'S NAME<br><b>HENRY WILLIAMS</b>   |  |                                      |  |   |  | 14. MOTHER'S MAIDEN NAME<br><b>ELLA BADGE</b>  |  |   |  |  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)<br>(If yes give war or dates of service)   |  |                                      |  | 16. SOCIAL SECURITY NO.<br><b>218-03-1882</b>   |  | 17. INFORMANT Address<br><b>Mrs. D. Williams 612 New Pittsburg Ave.</b>  |  |   |  |  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Carcinoma of lung</b><br>100% DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, }<br>(b) _____ DUE TO<br>(c) _____<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br>19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |                                      |  |   |  |  |  |   |  |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |                                      |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)  |  |  |  |   |  |  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. _____ p.m. <b>19</b>   |  |                                      |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>   |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |  | 20f. (City or town) (County) (State)              |  |  |  |
| 21. I certify that (I) (this hospital) attended the deceased from <b>11/10</b> , 19 <b>67</b> , to <b>12/15</b> , 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>12/15</b> , 19 <b>67</b> , and that death occurred at <b>7:25 M.</b> from the causes and on the date stated above.  |  |                                      |  |   |  |  |  |   |  |  |  |
| 22a. SIGNATURE<br><b>John E. Adams</b>   |  |                                      |  |   |  | M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> |  | 22b. DATE SIGNED<br><b>12/16/67</b>               |  |  |  |
| 22c. PHYSICIAN'S NAME (Type)<br><b>John E. Adams, M.D.</b>   |  |                                      |  |   |  | 22d. ADDRESS<br><b>6701 N. Charles Street</b>  |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>   |  | 23b. DATE THEREOF<br><b>12-21-67</b> |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Mount Auburn Cem.</b>  |  | 23d. LOCATION (City, town or county) (State)<br><b>Baltimore, Maryland</b>   |  |   |  |  |  |
| 24. FUNERAL DIRECTOR<br><b>McRae &amp; Vignati</b>   |  |                                      |  |   |  | ADDRESS  |  | 25a. REC'D BY REGISTRAR<br><b>DEC 19 1967</b>     |  | 25b. REGISTRAR'S SIGNATURE<br><b>Julianus Judge</b>        |  |

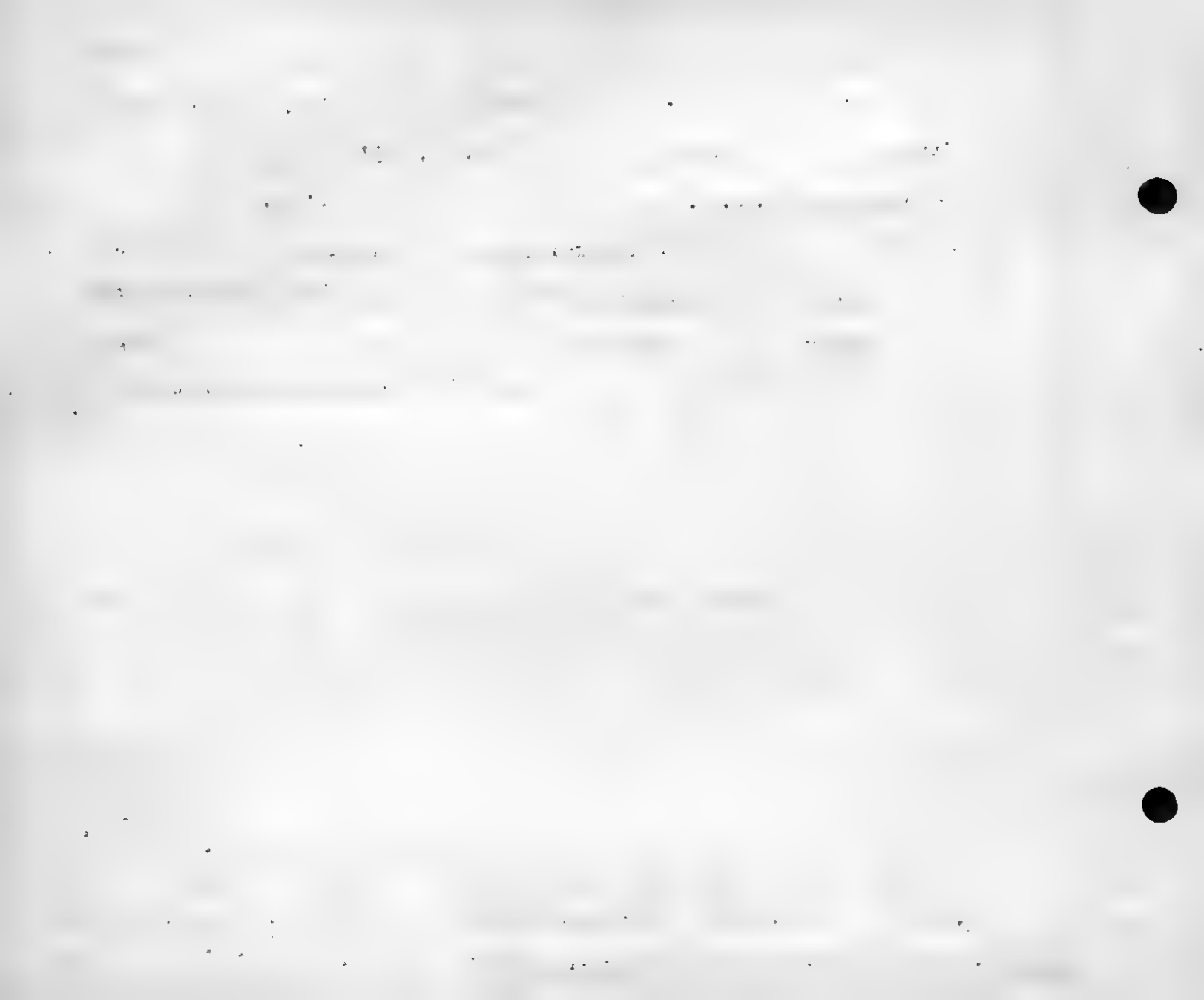


TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 415  
30M REV. 7-68

| MARYLAND STATE DEPARTMENT OF HEALTH   |  |  |   |  |   |   |  |  |   |  |                 |  |
|---|--|--|---|--|---|---|--|--|---|--|-----------------|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |  |  |   |  |   |   |  |  |   |  |                 |  |
| CERTIFICATE OF DEATH  |  |  |   |  |   |   |  |  |   |  |                 |  |
| 1. DECEASED-NAME<br>(Type or print) <b>Ora S. Williams</b>  |  |  |   |  |   | 2a. DATE OF DEATH<br>Month <b>Dec.</b> Day <b>29</b> Year <b>1967</b>                                       |  |  | 2b. HOUR<br><b>M</b>                                    |  |                 |  |
| 3. SEX<br><b>Female</b>   |  | 4. RACE<br><b>White</b>  |   | 5. DATE OF BIRTH<br><b>Oct. 14, 1897</b>   |   |   | 6. AGE (In years last birthday)<br><b>70</b> YRS   |  | IF UNDER YEAR MONTHS DAYS HOURS MIN.                    |  | IF UNDER 24 HRS |  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>XX Virginia</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U. S. A.</b>                              |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |   | 9. COUNTY OF DEATH<br><b>Balto.</b>   |  |  |   |  |                 |  |
| 10. CITY OR TOWN OF DEATH<br><b>Rosedale</b>  |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>2322 Hamiltowne Circle</b> |  |   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)<br><b>Salesclerk</b> |  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Dept. Store</b> |  |                 |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><b>Md.</b>   |  |  | 13b. COUNTY<br><b>Baltimore</b>   |  | 13c. CITY OR TOWN<br><b>Rosedale</b>  |   | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET AND NUMBER<br><b>2322 Hamiltowne Circle</b> |  |                 |  |
| 14. FATHER'S NAME First Middle Last<br><b>Lawrence Anderson</b>   |  |  |   | 15. MOTHER'S MAIDEN NAME First Middle Last<br><b>Core Edwards</b>  |   |   |  |  |   |  |                 |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown  |  |  | 16b. SOCIAL SECURITY NO   |  | 17. INFORMANT Address<br><b>Mrs. Richard Novak, 2322 Hamiltowne Circle</b>        |   |  |  |   |  |                 |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Carcinoma Gall Bladder</u><br><b>1551</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |  |   |  |   |   |  |  |   |  |                 |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)  |  |  |   |  |   |   |  |  |   |  |                 |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |   |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                         |  |   |  |                 |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <b>19</b>            |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)  |   |   |  |  |   |  |                 |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |   | 21f. LOCATION Street or R.F.D. No. City or Town County State   |   |   |  |  |   |  |                 |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>12/27/67</u> , 19 <u>67</u> , to <u>12/30/67</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>12/27/67</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |  |   |  |   |   |  |  |   |  |                 |  |
| 22b. SIGNATURE<br><u>John G. Orth, M.D.</u>   |  |  |   | DEGREE ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>                               |   | 22c. DATE SIGNED<br><u>12/30/67</u>   |  |  |   |  |                 |  |
| 22d. PHYSICIAN'S NAME (Type)  |  |  |   | 22e. ADDRESS<br><u>8019 Philadelphia Rd.</u>   |   |   |  |  |   |  |                 |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |  | 23b. DATE<br><b>Jan. 2, 1968</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Woodlawn Cemetery</b>   |   |   | 23d. LOCATION (City or Town) (County) (State)<br><b>Baltimore County, Maryland</b>           |  |   |  |                 |  |
| 24. FUNERAL DIRECTOR<br><b>G. Truman Schwab, 3512 Frederick Ave., Baltimore Maryland, 21228</b>   |  |  |   | ADDRESS  |   | 25a. REC'D BY REGISTRAR<br>DATE <b>JAN 2 1968</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><u>[Signature]</u> |   |  |                 |  |





DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

|  |                              |  |  |
|--|------------------------------|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY<br><b>BALTIMORE</b><br>b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)<br><b>BALTIMORE</b><br>c. LENGTH OF STAY IN 1b<br><b>BALTIMORE</b><br>d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)<br><b>7903 BROOKHAVEN ROAD</b>                       |                              | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)<br>e. STATE<br><b>MARYLAND</b><br>b. COUNTY<br><b>BALTIMORE</b><br>c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)<br><b>BALTIMORE</b><br>d. STREET ADDRESS<br><b>7903 BROOKHAVEN RD</b><br>e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 3. NAME OF DECEASED (Type or print)<br><b>FRANCES D. WILLNER</b>   |                              | 4. DATE OF DEATH<br><b>DEC 15 1967</b>   |  |
| 5. SEX<br><b>F</b>   | 6. COLOR OR RACE<br><b>W</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>  | 8. DATE OF BIRTH<br><b>DEC 3, 1912</b> |
| 9. AGE (In years last birthday)<br><b>55 yrs.</b>  |                              | 10. IF UNDER 1 YEAR<br>Months Days Hours Min.  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>CLERK</b>  |                              | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>SOCIAL SECURITY</b>  |  |
| 11. BIRTHPLACE (County & State, or foreign country)<br><b>NEW YORK</b>   |                              | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  |
| 13. FATHER'S NAME<br><b>JOSEPH</b>   |                              | 14. MOTHER'S MAIDEN NAME<br><b>NETTIE</b>  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><b>NO</b>   |                              | 16. SOCIAL SECURITY NO.<br><b>SAMUEL H. WILLNER</b>  |  |
| 17. INFORMANT<br><b>SAME</b>   |                              | Address  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Wide spread metastases</b><br>DUE TO <b>Carcinoma of Lung</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } DUE TO (b) <b>Jan 67</b><br>(c) <b>Jan 67</b> |                              |  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Interval between onset and death</b>  |                              |  |  |
| 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                              |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                              | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m. <b>19</b>   |                              | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>   |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |                              | 20f. (City or town) (County) (State)   |  |
| 21. I certify that (I) (the hospital) attended the deceased from <b>Jan 1967</b> to <b>Dec 15 1967</b> , that (I) (we) last saw the deceased alive on <b>Dec 4 PM 1967</b> , and that death occurred at <b>4:00 PM</b> from the causes and on the date stated above.   |                              |  |  |
| 22a. SIGNATURE<br><b>E.T. Lisansky</b> M.D.  |                              | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> <b>Dec 16/67</b>   |  |
| 22c. PHYSICIAN'S NAME (Type)<br><b>E.T. LISANSKY</b>   |                              | 22d. ADDRESS<br><b>6804 PKHS Ave (15)</b>  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>   |                              | 23b. DATE THEREOF<br><b>12/18/1967</b>   |  |
| 23c. NAME OF CEMETERY OR CREMATORY<br><b>Mt Hope</b>   |                              | 23d. LOCATION (City, town or county) (State)<br><b>York New York</b>   |  |
| 24. FUNERAL DIRECTOR'S SIGNATURE<br><b>Sylvan S. Lewis &amp; Son, INC.</b>   |                              | 25a. REC'D BY REGISTRAR<br><b>DEC 19 1967</b>  |  |
| ADDRESS<br><b>Garrison, Maryland</b>   |                              | 25b. REGISTRAR'S SIGNATURE<br><b>James J. Jones</b>  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AIS  
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
10729  
10724  
**CERTIFICATE OF DEATH**

|   |   |  |  |
|---|---|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>BALTIMORE</b><br>b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b><br>c. LENGTH OF STAY IN 1b <b>9 days</b><br>d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Greater Baltimore Medical Center</b>   |   | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Balto.</b><br>c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b><br>d. STREET ADDRESS <b>125 Dumbarton Road #21212</b><br>e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>EVELYN</b> Middle <b>ANGELINE</b> Last <b>WILSON</b>  |   | 4. DATE OF DEATH<br>Month <b>12</b> Day <b>27</b> Year <b>19 67</b>  |  |
| 5. SEX <b>F</b>   | 6. COLOR OR RACE <b>CAU</b>   | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDDED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>   | 8. DATE OF BIRTH <b>07-10-01</b>   |
| 9. AGE (In years last birthday) <b>66 yrs.</b>  |   | IF UNDER 1 YEAR IF UNDER 24 HRS.<br>Months Days Hours Min.   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>  |   | 10b. KIND OF BUSINESS OR INDUSTRY <b>-----</b>   |  |
| 11. BIRTHPLACE (County & State, or foreign country) <b>Baltimore, Maryland</b>  |   | 12. CITIZEN OF WHAT COUNTRY? <b>USA</b>  |  |
| 13. FATHER'S NAME <b>Robert DeHuff</b>  |   | 14. MOTHER'S MAIDEN NAME <b>ROSE Drane</b>   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes give war or dates of service)   |   | 16. SOCIAL SECURITY NO. <b>216-38-1418</b><br><b>UNKNOWN</b>   |  |
| 17. INFORMANT <b>Mrs. Paul C. Botsford</b>  |   | Address <b>Glenarm, Md.</b><br><b>Patient's History</b>  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>1. pneumonia</b><br>DUE TO <b>generalized Metastatic carcinoma</b><br>(b) <b>carcinoma of heart</b><br>DUE TO<br>(c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) |   |  | INTERVAL BETWEEN ONSET AND DEATH   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> DR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m. <b>19</b>  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   | 20f. (City or town) (County) (State)                                     |
| 21. I certify that (I) (this hospital) attended the deceased from <b>12-18</b> , 19 <b>67</b> , to <b>12-27</b> , 19 <b>67</b> ; that (I) (we) last saw the deceased alive on <b>9-20 AM 12</b> , 19 <b>67</b> , and that death occurred at <b>2:40 AM</b> , from the causes and on the date stated above.  |   |  |  |
| 22a. SIGNATURE <b>Dr. G. Maghami</b>  |   | 22b. DATE SIGNED <b>12/27/67</b>   |  |
| 22c. PHYSICIAN'S NAME (Type)  |   | 22d. ADDRESS <b>125 Dumbarton RD;</b>  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>   | 23b. DATE THEREOF <b>12/29/67</b>   | 23c. NAME OF CEMETERY OR CREMATORY <b>Parkwood</b>   | 23d. LOCATION (City or town or county) (State) <b>Baltimore Maryland</b> |
| 24. FUNERAL DIRECTOR <b>Mitchell-Wiedefeld Home</b> ADDRESS <b>6500 York Rd.</b>  |   | 25a. REC'D BY REGISTRAR <b>JAN 3 1968</b> DATE <b>Charles Judge</b>  |  |
| 25b. REGISTRAR'S SIGNATURE  |   |  |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove casket papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

VR A15 (4)  
25M 1/67

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |  |  |  |   |  |  |  |   |  |
|---|--|--|--|---|--|--|--|---|--|
| 16730 Item #2d Film #G3:6 12/20/67  |  |  |  |   |  |  |  |   |  |
| CERTIFICATE OF DEATH  |  |  |  |   |  |  |  |   |  |
| 10725   |  |  |  |   |  |  |  |   |  |
| 1. PLACE OF DEATH<br>a. COUNTY <u>Baltimore</u> MARYLAND  |  |  |  |   | 2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission)<br>a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> |  |  |   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Towson</u>   |  |  | c. LENGTH OF STAY IN 1b                              |   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Towson</u>  |  |  |   |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><u>Todd Convalescent Home</u>   |  |  |  |   | d. STREET ADDRESS<br><u>17 Florida Avenue</u><br><u>Todd Convalescent Home</u>   |  |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 3. NAME OF DECEASED<br>(Type or print) <u>Georgia F. "Wilson"</u>   |  |  |  |   | 4. DATE OF DEATH<br>Month <u>December</u> Day <u>1</u> Year <u>1967</u>  |  |  |   |  |
| 5. SEX<br><u>Female</u>   |  | 6. COLOR OR RACE<br><u>"White"</u>   |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><u>March 20, 1879</u>                                |  | 9. AGE (In years last birthday) yrs <u>88</u>   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Housewife</u>   |  |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>Own Home</u> |   |  | 11. BIRTHPLACE (County & State, or foreign country)<br><u>Maryland</u>   |  | 12. CITIZEN OF WHAT COUNTRY?<br><u>U.S.</u>   |  |
| 13. FATHER'S NAME<br><u>Arthur Flather</u>  |  |  |  |   | 14. MOTHER'S MAIDEN NAME<br><u>Mary Francis Shipley</u>  |  |  |   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><u>No</u>  |  |  | 16. SOCIAL SECURITY NO.<br><u>None</u>               |   | 17. INFORMANT<br><u>Family records</u>   |  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u><br>DUE TO (b) <u>Arteriosclerotic Cardio-renal</u><br>DUE TO (c) <u>Vascular Disease</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost |  |  |  |   |  |  |  | INTERVAL BETWEEN ONSET AND DEATH<br><u>2 hrs</u>  |  |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)  |  |  |  |   |  |  |  | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)   |  |  |  |   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m. <u>19</u>  |  | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Not While <input type="checkbox"/><br>at work at work |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)   |  | 20f. (City or town) (County) (State)                                     |  |   |  |
| 21. I certify that (I) (this hospital) attended the deceased from <u>10/1, 1966</u> to <u>12/1, 1967</u> that (I) <u>did</u> last saw the deceased alive on <u>19</u> , and that death occurred at <u>M</u> , from causes and on the date stated above.   |  |  |  |   |  |  |  |   |  |
| 22a. SIGNATURE<br><u>Charles F. Donald</u>  |  |  |  |   | 22b. DATE SIGNED   |  |  | 22c. PHYSICIAN'S NAME (Type)<br><u>Charles F. Donald</u>  |  |
| 22d. ADDRESS  |  |  |  |   | 22e. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>         |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>burial</u>  |  | 23b. DATE THEREOF<br><u>Dec. 7, 1967</u>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Ft. Lincoln Cemetery</u>   |  | 23d. LOCATION (City or Town) (County) (State)<br><u>Washington, D.C.</u> |  |   |  |
| 24. FUNERAL DIRECTOR<br><u>Go. Burns' Sons, Towson, Maryland</u>  |  |  |  |   | 25a. REC'D BY REGISTRAR<br>DATE <u>DEC 11 1967</u>   |  | 25b. REGISTRAR'S SIGNATURE<br><u>Charles Jones</u> |   |  |



CERTIFICATE OF DEATH

16731

15721

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL CERTIFICATION

|  |                               |   |   |
|--|-------------------------------|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Baltimore</u>  |                               | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)<br>a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>                |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Keisterstown</u>   |                               | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Keisterstown</u>  |   |
| c. LENGTH OF STAY IN TB <u>4 years</u>   |                               | d. STREET ADDRESS <u>102 Chestnut Hill Lane</u>   |   |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)   |                               | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |   |
| 3. NAME OF DECEASED (Type or print) <u>DREXEL N.M.W. WINNER</u>  |                               | 4. DATE OF DEATH <u>December 24 1967</u>  |   |
| 5. SEX <u>Male</u>   | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>    | 8. DATE OF BIRTH <u>February 9 1908</u> |
| 9. AGE (In years last birthday) <u>59</u> yrs.   |                               | 10. IF UNDER 1 YEAR Months Days Hours Min.  |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Social Security</u>   |                               | 10b. KIND OF BUSINESS OR INDUSTRY <u>Social Security</u>  |   |
| 11. BIRTHPLACE (Country & State, or foreign country) <u>Pennsylvania U.S.A.</u>  |                               | 12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>   |   |
| 13. FATHER'S NAME <u>Anthony Joseph Drexel Winner</u>  |                               | 14. MOTHER'S MAIDEN NAME <u>Helen Flora Roberts</u>   |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>   |                               | 16. SOCIAL SECURITY NO. <u>203-28-6800</u>  |   |
| 17. INFORMANT <u>Anne M.W. Winner</u>  |                               | Address <u>102 Chestnut Hill Lane</u>   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Carcinoma - lung - left</u><br>16 yr<br>CONDITIONS, if any, which gave rise to immediate cause (b) <u>16 yr</u><br>(a), stating the underlying cause last. (c) <u>16 yr</u> |                               | INTERVAL BETWEEN ONSET AND DEATH <u>8 months</u>  |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)  |                               |   |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                               | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m. <u>19</u>   |                               | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/> |   |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |                               | 20f. (City or town) (County) (State)  |   |
| 21. I certify that (I) (this hospital) attended the deceased from <u>May 1967</u> to <u>December 24, 1967</u> , that (I) (we) last saw the deceased alive on <u>December 20, 1967</u> , and that death occurred at <u>5:45 AM</u> , from the causes and on the date stated above.                              |                               |   |   |
| 22a. SIGNATURE <u>Clarence E. McWilliams</u> M.D.  |                               | 22b. DATE SIGNED <u>12-24-67</u>  |   |
| 22c. PHYSICIAN'S NAME (Type) <u>Dr. Clarence E. McWilliams</u>   |                               | 22d. ADDRESS <u>11904 Keisterstown Rd. Keisterstown Md.</u>   |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)  |                               | 23b. DATE THEREOF <u>12/26/67</u>   |   |
| 23c. NAME OF CEMETERY OR CREMATORY <u>Johns Hop. School of Med.</u>  |                               | 23d. LOCATION (City, town or county) (State) <u>709 N. Wolfe St., Balto.</u>  |   |
| 24 FUNERAL DIRECTOR'S SIGNATURE  |                               | 25a. REC'D BY REGISTRAR <u>DEC 29 1967</u>  |   |
| ADDRESS  |                               | 25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>   |   |





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1, 2 and 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

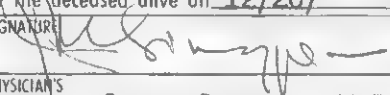

VR A15 (4)  
25M 1/67

16732

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

16728

|  |   |   |  |  |   |
|--|---|---|--|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY<br><b>Baltimore</b><br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Towson</b><br>c. LENGTH OF STAY IN Tb   |   |   | 2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)<br>a. STATE<br><b>Maryland</b><br>b. COUNTY<br><b>Baltimore 21212</b><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Baltimore 21212</b> |  |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>ST. JOSEPH HOSPITAL</b>   |   |   | d. STREET ADDRESS<br><b>241 Rodgers Forge Rd.</b>  |  |   |
| 3. NAME OF DECEASED<br>(Type or print)<br>First Middle Last<br><b>William Mitchel WOZNIAK</b>  |   |   | 4. DATE OF DEATH<br>Month Day Year<br><b>December 20, 19 67</b>  |  |   |
| 5. SEX<br><b>Male</b>  | 6. COLOR OR RACE<br><b>White</b>  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>October 31, 1914</b>  | 9. AGE (In years lost birthday)<br><b>53</b> yrs | 10. UNDER 1 YEAR<br>Months Days Hours Min   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)  |   | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Real Estate</b>   | 11. BIRTHPLACE (County & State, or foreign country)<br><b>Massachusetts</b>  |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |
| 13. FATHER'S NAME<br><b>V.M. Wozniak</b>   |   |   | 14. MOTHER'S MAIDEN NAME<br><b>Ladislai SEULPIN</b>  |  |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><b>yes- peacetime</b>   |   | 16. SOCIAL SECURITY NO<br><b>026-10 8733</b>  | 17. INFORMANT<br>Address<br><b>Beverly J. Wozniak 241 Rogers Forge Rd.</b>   |  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cerebral hemorrhage</b><br>DUE TO (b) _____<br>DUE TO (c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.                 |   |   |  |  | INTERVAL BETWEEN ONSET AND DEATH  |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |   |   |  |  | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |   | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)  |  |  |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m. 19  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  | 20f. (City or town) (County) (State)   |  |   |
| 21. I certify that <b>NO</b> (this hospital) attended the deceased from <b>12/16/</b> 19 <b>67</b> , to <b>12/20/</b> 19 <b>67</b> that <b>NO</b> (we) last saw the deceased alive on <b>12/20/</b> 19 <b>67</b> , and that death occurred on <b>12/20/</b> 19 <b>67</b> , from causes and on the date stated above. |   |   |  |  |   |
| 22a. SIGNATURE<br>  |   |   | 22b. DATE SIGNED<br><b>12/20/67</b>  |  |   |
| 22c. PHYSICIAN'S NAME (Type)<br><b>Jaime Singzon, M.D.</b>   |   |   | 22d. ADDRESS<br><b>7620 York Rd., Towson, Md. 21204</b>  |  |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   | 23b. DATE THEREOF<br><b>12/23/67</b>  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Dulaney Valley Mem. Grds.</b>  | 23d. LOCATION (City or Town) (County) (State)<br><b>Balto. County Md.</b>  |  |   |
| 24. FUNERAL DIRECTOR<br><b>Mitchell-Wiedefeld Home</b>   |   |   | 25a. REC'D BY REGISTRAR<br>DATE <b>DEC 29 1967</b>   |  |   |
| ADDRESS<br><b>6500 York Rd.</b>  |   |   | 25b. REGISTRAR'S SIGNATURE<br>  |  |   |
| <b>Balto., Md. 21212</b>   |   |   |  |  |   |

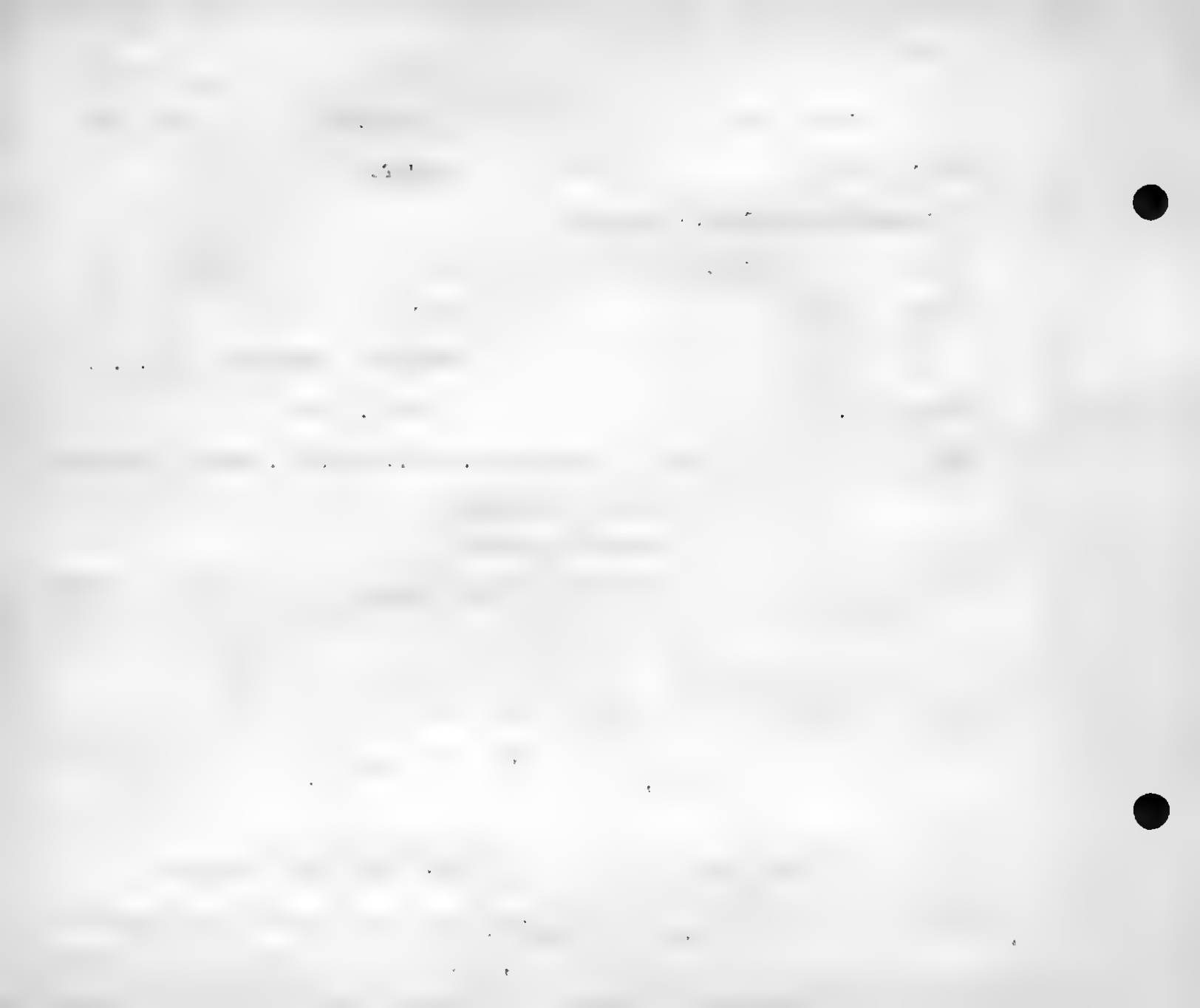
\* 100-1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

| MARYLAND STATE DEPARTMENT OF HEALTH   |  |                                      |  |   |   |  |  |   |  |  |
|---|--|--------------------------------------|--|---|---|--|--|---|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |  |                                      |  |   |   |  |  |   |  |  |
| Item # 2-b Filing # 396 12/28/67 km   |  |                                      |  |   |   |  |  |   |  |  |
| 1673c CERTIFICATE OF DEATH 15721  |  |                                      |  |   |   |  |  |   |  |  |
| 1. PLACE OF DEATH<br>a. COUNTY <b>BALTIMORE</b><br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>PORT HOWARD</b><br>c. LENGTH OF STAY IN 1b <b>35 DAYS</b><br>d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>VETERANS ADMINISTRATION HOSPITAL</b>  |  |                                      |  |   | 2. USUAL RESIDENCE (Where deceased lived, if institution or Residence before admission)<br>a. STATE <b>MARYLAND</b> b. COUNTY <b>ANNE ARUNDEL</b><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>EDGEWATER</b><br>d. STREET ADDRESS<br>e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |   |  |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>CHARLES</b> Middle <b>LEO</b> Last <b>WITT</b>  |  |                                      |  |   | 4. DATE OF DEATH<br>Month <b>DECEMBER</b> Day <b>15</b> Year <b>19 67</b>   |  |  |   |  |  |
| 5. SEX <b>MALE</b>  |  | 6. COLOR OR RACE <b>WHITE</b>        |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |   | 8. DATE OF BIRTH<br><b>9 23 15</b>   |  | 9. AGE (In years last birthday) <b>52</b><br>If UNDER 1 YEAR, Months Days Hours Min |  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)   |  |                                      |  | 10b. KIND OF BUSINESS OR INDUSTRY   |   | 11. BIRTHPLACE (County & State, or foreign country) <b>SHADYSIDE, MARYLAND</b> |  |   | 12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>   |  |
| 13. FATHER'S NAME<br><b>CHARLES F. WITT</b>   |  |                                      |  |   | 14. MOTHER'S MAIDEN NAME<br><b>MARTHA R. TROTT</b>  |  |  |   |  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>YES</b><br>WW-11   |  |                                      |  | 16. SOCIAL SECURITY NO.<br><b>220 16 5114</b>   |   | 17. INFORMANT<br><b>CLIN. REC., VAH, FT. HOWARD, MARYLAND</b>                  |  |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <b>GANGRENE OF BOWELS</b><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(b) <b>MESENTERIC EMBOLISM</b><br>DUE TO<br>(c) <b>GENERALIZED ARTERIOSCLEROSIS AND THROMBO-</b> |  |                                      |  |   |   |  |  |   | INTERVAL BETWEEN ONSET AND DEATH<br><b>DAYS</b><br><b>MONTHS</b>                               |  |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |  |                                      |  |   |   |  |  |   | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |                                      |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)   |   |  |  |   |  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour <b>p.m.</b> <b>19</b>  |  |                                      |  | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Not While <input type="checkbox"/><br>at work at work  |   | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)         |  | 20f. (City or town) (County) (State)  |  |  |
| 21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>Nov. 10 1967</b> , to <b>Dec. 15, 1967</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>Dec. 15, 1967</b> , and that death occurred at <b>3:45 p.m.</b> from causes and on the date stated above                              |  |                                      |  |   |   |  |  |   |  |  |
| 22a. SIGNATURE<br><i>George Dudas</i>   |  |                                      |  |   | M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>  |  |  | 22b. DATE SIGNED<br><b>12 16 67</b>   |  |  |
| 22c. PHYSICIAN'S NAME (Type)<br><b>GEORGE DUDAS, MD</b>   |  |                                      |  |   | 22d. ADDRESS<br><b>VAH, PORT HOWARD, MARYLAND</b>   |  |  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>  |  | 23b. DATE THEREOF<br><b>12-18-67</b> |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>CHRIST CHURCH CEMETERY</b>   |   |  | 23d. LOCATION (City or Town) (County) (State)<br><b>OWENSVILLE, MARYLAND</b> |   |  |  |
| 24. FUNERAL DIRECTOR<br><i>Harry Hutchins</i>   |  |                                      |  |   | ADDRESS<br><b>Hutchins Funeral Home</b><br><b>Owings, Md.</b>   |  | 25a. REC'D BY REGISTRAR<br><b>DEC 20 1967</b>                                |   | 25b. REGISTRAR'S SIGNATURE<br><i>Charles Judge</i>   |  |



CERTIFICATE OF DEATH

16729

|  |  |   |  |
|--|--|---|--|
| 1 PLACE OF DEATH<br>a. COUNTY<br><b>Baltimore</b><br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Towson</b><br>c. LENGTH OF STAY IN 1b<br><b>Baltimore 21212</b>  |  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE<br><b>Maryland</b><br>b. COUNTY<br><b>Baltimore</b><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Baltimore 21212</b> |  |
| 3. NAME OF DECEASED<br>(Type or print)<br><b>Perdue</b><br>First Middle Last<br><b>A WYMORE</b>  |  | 4. DATE OF DEATH<br>Month Day Year<br><b>December 30 1967</b>   |  |
| 5. SEX<br><b>male</b>  | 6. COLOR OR RACE<br><b>white</b>   | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>   | 8. DATE OF BIRTH<br><b>2-28-07</b>                                     |
| 9. AGE (In years lost birthday)<br><b>60 yrs.</b>  |  | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Retired U.S. Army</b>  |  |
| 11. BIRTHPLACE (County & State or foreign country)<br><b>Iowa</b>  |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  |
| 13. FATHER'S NAME<br><b>? Wymore</b>   |  | 14. MOTHER'S MAIDEN NAME<br><b>Unknown</b>  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) (If yes give year or dates of service)<br><b>Yes 29 Years</b>   |  | 16. SOCIAL SECURITY NO<br><b>216-34-6887</b>  |  |
| 17. INFORMANT<br><b>Mrs. Olivia Wymore</b>   |  | Address<br><b>(Same)</b>  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY:<br><b>154 X</b> IMMEDIATE CAUSE (a) <b>generalized carcinomatosis of abdomen</b><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>carcinoma of rectum</b><br>DUE TO (c) |  |   | INTERVAL BETWEEN ONSET AND DEATH                                       |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |  |   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)   |  | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour: a.m. p.m.<br><b>19</b>   | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  | 20f. (City or town) (County) (State)                                   |
| 21. I certify that (I) (this hospital) attended the deceased from <b>December 29, 1967</b> to <b>December 30, 1967</b> , that (I) (we) last saw the deceased alive on <b>December 30, 1967</b> , and that death occurred at <b>5:20 P.M.</b> from causes and on the date stated above.   |  |   |  |
| 22a. SIGNATURE<br><b>Freidoon Malek</b>  |  | 22b. DATE SIGNED<br><b>12-30-67</b>   |  |
| 22c. PHYSICIAN'S NAME (Type)<br><b>Dr. Freidoon Malek</b>  |  | 22d. ADDRESS<br><b>7620 York Road, Baltimore 21204 Md</b>   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   | 23b. DATE THEREOF<br><b>1/4/68.</b>  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Balto. National Cem.</b>   | 23d. LOCATION (City or Town) (County) (State)<br><b>Baltimore, Md.</b> |
| 24. FUNERAL DIRECTOR<br><b>Leonard J. Ruck, Inc. Balto. Md. 21214</b>  |  | 25a. REC'D BY REGISTRAR<br>DATE <b>JAN 2 1968</b>   |  |
|  |  | 25b. REGISTRAR'S SIGNATURE<br><b>James Judge</b>  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



Item 1885, film #395  
 12-12-67 mt  
 16735  
 DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
 CERTIFICATE OF DEATH  
 16730

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2, and return them to the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death. This should be filed with the State Dept of Health.

|  |   |  |  |
|--|---|--|--|
| 1. PLACE OF DEATH<br>a COUNTY <u>Baltimore</u> MARYLAND  |   | 2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)<br>a STATE <u>md.</u> b COUNTY <u>Balt</u>                             |  |
| b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Cockeysville</u>   |   | c LENGTH OF STAY IN 1b<br><u>5 yr 10 mo</u>  |  |
| d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><u>Bonnie Blank Masonic Homes</u>   |   | e IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |
| 3 NAME OF DECEASED<br>(Type or print)<br>First <u>Deisy</u> Middle <u>E.</u> Last <u>Yingling</u>  |   | 4 DATE OF DEATH<br>Month <u>12</u> Day <u>1</u> Year <u>1967</u>   |  |
| 5 SEX <u>F</u>   | 6 COLOR OR RACE <u>W</u>  | 7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8 DATE OF BIRTH<br><u>2-10-1878</u>  |
| 9 AGE (In years last birthday)<br><u>89 yrs</u>  |   | 10 IF UNDER 1 YEAR<br>Months <u>1</u> Days <u>1</u> Hours <u>1</u> Min <u>1</u>  |  |
| 10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Homemaker</u>   |   | 10b KIND OF BUSINESS OR INDUSTRY<br><u>Home</u>  |  |
| 11 BIRTHPLACE (County & State, or foreign country)<br><u>Baltimore md.</u>   |   | 12 CITIZEN OF WHAT COUNTRY?<br><u>USA</u>  |  |
| 13 FATHER'S NAME<br><u>William Harber</u>  |   | 14 MOTHER'S MAIDEN NAME<br><u>Christina Spies</u>  |  |
| 15 WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) (If yes give war or dates of service)<br><u>No</u>   |   | 16 SOCIAL SECURITY NO<br><u>215-01-2873B</u>   |  |
| 17 INFORMANT<br><u>Same as</u>   |   | Address <u>7th Masonic Home, #1</u>  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I DEATH WAS CAUSED BY<br>331V IMMEDIATE CAUSE (a) <u>Cerebrovascular accident</u><br>DUE TO <u>recurrent</u><br>(b) <u>Advanced senility</u><br>DUE TO <u>fractured hip</u> June 1967<br>(c) <u>fractured hip</u> |   |  |  |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br><u>None</u>  |   |  |  |
| 20a ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |   | 20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II. of item 18)   |  |
| 20c TIME OF INJURY Month, Day, Year<br>Hour a.m. <u>19</u> p.m.  | 20d INJURY OCCURRED<br>While <input type="checkbox"/> Not While <input type="checkbox"/><br>at work at work | 20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  | 20f (City or town) (County) (State)  |
| 21. I certify that (I) (this hospital) attended the deceased from <u>April 1965</u> to <u>Nov 30, 1967</u> that (I) (we) last saw the deceased alive on <u>Nov 30, 1967</u> , and that death occurred at <u>1300</u> M, from causes and on the date stated above.                                  |   |  |  |
| 22a SIGNATURE<br><u>JAMES H. HAMED</u> M.D.  |   | 22b DATE SIGNED<br><u>12/1/67</u>  |  |
| 22c PHYSICIAN'S NAME (Type)<br><u>JAMES H. HAMED</u>   |   | 22d ADDRESS<br><u>MASONIC HOME, Cockeysville, Md.</u>  |  |
| 23a BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial</u>  | 23b DATE THEREOF<br><u>Dec 4, 1967</u>  | 23c NAME OF CEMETERY OR CREMATORY<br><u>Landon Park Cemetery</u>   | 23d LOCATION (City or Town) (County) (State)<br><u>Baltimore, Maryland</u> |
| 24 FUNERAL DIRECTOR<br><u>Wm. Carl Brooks Towson</u>   |   | 25a REC'D BY REG. STRAR<br><u>DEC 5 1967</u>   |  |
| ADDRESS<br><u>1050 York Rd Towson Md</u>   |   | 25b REGISTRAR'S SIGNATURE<br><u>J. Charles Judge</u>   |  |





# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

16736

16731

Reg. Dist. No.

FOR STATE  
HEALTH DEPT.

|  |  |   |  |  |  |   |  |
|--|--|---|--|--|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>BALTIMORE</b> MARYLAND   |  |   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>MD</b> 21222 b. COUNTY <b>BALTIMORE</b>             |  |   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>DUNDALK</b>   |  | c. LENGTH OF STAY IN 1b<br><b>7 YRS</b>   |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>DUNDALK</b>   |  |   |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>1973 SNYDER AVE</b>   |  |   |  | d. STREET ADDRESS<br><b>1973 SNYDER AVE.</b>   |  |   |  |
| 3. NAME OF DECEASED (Type or print) First Middle Last<br><b>LEONA SCHAEFER YOUNG</b>   |  |   |  | 4. DATE OF DEATH Month Day Year<br><b>12/28/67 19</b>  |  |   |  |
| 5. SEX<br><b>FEMALE</b>  |  | 6. COLOR OR RACE<br><b>WHITE</b>  |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><b>OCT. 28, 1897</b>                              |  |
| 9. AGE (In years last birthday)<br><b>70</b> yrs.  |  | IF UNDER 1 YEAR<br>Months Days Hours Min.   |  | IF UNDER 24 HRS.   |  |   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>SEAMSTRESS</b>   |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>TAILORING</b>   |  | 11. BIRTHPLACE (State or foreign country)<br><b>MD.</b>  |  | 12. CITIZEN OF WHAT COUNTRY?  |  |
| 13. FATHER'S NAME<br><b>JOSEPH SCHAEFER</b>  |  |   |  | 14. MOTHER'S MAIDEN NAME<br><b>MADELINE WAGNER</b>   |  |   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><b>NO</b>  |  | 16. SOCIAL SECURITY NO.<br><b>216-10-7542</b>   |  | 17. INFORMANT Address<br><b>CAROLINE D. LETTS AS IN #2 ABOVE</b>   |  |   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>A-S-C-V-Disease</b><br>4221<br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) _____<br>(c) _____<br>DUE TO<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____<br>INTERVAL BETWEEN ONSET AND DEATH _____ |  |   |  |  |  |   |  |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)<br><b>None</b> |  |  |  |   |  |
| 20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year<br><b>19</b>   |  | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>      |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |  | 20f. (City or town) (County) (State)                                  |  |
| 21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> . Inspection <input type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>   |  |   |  |  |  |   |  |
| ACTUAL SIGNATURE <b>M B DAVIS</b>  |  |   |  | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>   |  |   |  |
| EXAMINER'S NAME (Type) <b>HELYN B. DAVIS M.D.</b>  |  |   |  | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>  |  |   |  |
|  |  |   |  | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <b>6800 MORNINGTON RD 21222</b>  |  |   |  |
| 22a. BURIAL, CREMATION, or REMOVAL (Specify)<br><b>BURIAL</b>  |  | 22b. DATE THEREOF<br><b>12/30/67</b>  |  | 22c. NAME OF CEMETERY OR CREMATORY<br><b>HOLY REDEEMER</b>   |  | 22d. LOCATION (City, town, or county) (State)<br><b>BALTIMORE, MD</b> |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>W. B. DAVIS</b>   |  |   |  | 24a. REC'D BY REGISTRAR<br><b>DEC 29 1967</b>  |  | 24b. REGISTRAR'S SIGNATURE<br><b>Charles Under</b>                    |  |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

15701

RTAD3



SLATE 1001



## CERTIFICATE OF DEATH

16732

|   |  |   |   |
|---|--|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY<br><b>Baltimore</b><br>MARYLAND  |  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. <b>MD</b><br>b. COUNTY  |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Towson 4</b>   |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Baltimore 21218</b>  |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>St. Joseph Hospital</b>  |  | d. STREET ADDRESS<br><b>1528 Roundhill Road</b>   |   |
| 3. NAME OF DECEASED<br>(Type or print) <b>Charles Zimmerman</b>   |  | 4. DATE OF DEATH<br>Month <b>December</b> Day <b>23</b> Year <b>1967</b>  |   |
| 5. SEX<br><b>Male</b>   | 6. COLOR OR RACE<br><b>White</b>   | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>February 20, 1902</b>  |
| 9. AGE (In years last birthday) yrs.<br><b>65</b>   |  | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Field Engineer</b>   |   |
| 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Bendix</b>  |  | 11. BIRTHPLACE (County & State, or foreign country)<br><b>Baltimore, Md.</b>  |   |
| 12. CITIZEN OF WHAT COUNTRY?<br><b>usa</b>  |  | 13. FATHER'S NAME<br><b>Charles Zimmerman</b>   |   |
| 14. MOTHER'S MAIDEN NAME<br><b>Effie Mae Baston</b>   |  | 15. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) <b>No</b> (If yes give year or dates of service) <b>None</b>                           |   |
| 16. SOCIAL SECURITY NO.   |  | 17. INFORMANT<br>Address<br><b>Mrs. Florence P. Zimmerman same address</b>  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Carcinoma of rectum with metastases to liver</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) _____<br>(c) _____<br>DUE TO |  |   | INTERVAL BETWEEN ONSET AND DEATH  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |  |   | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. _____ p.m. <b>19</b>  | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Not While <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  | 20f. (City or town) (County) (State)  |
| 21. I certify that <b>I</b> (this hospital) attended the deceased from <b>December 21, 1967</b> , to <b>December 23, 1967</b> , that <b>I</b> (we) last saw the deceased alive on <b>December 23, 1967</b> , and that death occurred at <b>8:10AM</b> , from causes and on the date stated above.                         |  |   |   |
| 22a. SIGNATURE<br><i>Eduardo Montelibano</i>  |  | 22b. DATE SIGNED<br><b>December 23, 1967</b>  |   |
| 22c. PHYSICIAN'S NAME (Type) <b>Eduardo Montelibano, M. D.</b>  |  | 22d. ADDRESS<br><b>7620 York Road, Towson 4 M. D.</b>   |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)   | 23b. DATE THEREOF<br><b>12/26/67</b>   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Lorraine Park Cemetery</b>   | 23d. LOCATION (City or Town) (County) (State)<br><b>Woodlawn, Md.</b>                             |
| 24. FUNERAL DIRECTOR<br><i>Wm. J. Tishman &amp; Sons</i>  |  | 25a. REC'D BY REGISTRAR<br>DATE <b>DEC 27 1967</b>  |   |
| ADDRESS <b>Baltimore, Md.</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><i>Charles Judge</i>  |   |

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



10000

10000

10000

10000

10000

10000

10000

10000

10000

10000

10000

10000

10000

10000

10000

10000

10000

10000

10000

10000

10000

10000

10000

10000

10000

10000